the corner of Woodland and South 12th Street. Driveway off of 12th. (615)500-6068

Old Hickory: Brandywine Farms 209 MONTCHANIN DRIVE Thurs/Fri/Sat 5/31-6/2 8am-3pm Garage/Estate Sale.

Davidson North

Madison- 1021 Woods Lake Dr. Fri 6/01 & Sat 6/02 8a-4p. **ESTATE SALE!!!** Antiques and vintage items.

ESTATE SALE

Madison, Estate Sale, 602 Tuckahoe Dr., 5/31, 6/1, 6/2, 8-4, 60 Years Accumulations, Antique & Vintage Furniture, Household, Lamps, Quilts, Blue Willow Dishes, Vintage Radios & Binoculars, Garage Full, Too much to list! 6154983648 (615)498-3648

Davidson Northeast

Madison, MOVING SALE!! Off of Maylene Dr, Saturday, June 2nd, 7am-12pm

Davidson Southeast

Antioch, Yard Sale, 409 Leisure Lane, 6/2/2018, 7AM -2PM, Dir: Off Old Hickory Blvd near Blue Hole Rd. Furniture, clothing, small appliances and LOTS MORE! (615)476-1378

Davidson Southwest

Bellevue: Sat, 6/2 , 7am-Noon. For mission trip,great items/prices. Western Hills Church 7565 Charlotte Ave.

Your merchandise is as good as gone. Call 242-SALE today.

Williamson County

Amazon Overstock Garage Sale 2707 Foxtrot Ln SH 37174 6/2 SAT 8-2 (no early birds) 95% NEW Household Tools Toys Baby Gear Clothing Shoes Sporting Goods Sm Appl/Electronics Beauty Bedding Home etc search FB Marketplace615 for pics

Brentwood, HUGE Multi-Family Sale/9473 Ashford Place/June 2, 7:30-2:00

Wilson County

Mt. Juliet, Leon Russell Estate Sale, 116 Clark Dr. Thurs-Sat, 830a-300p, 12 Keyboards, Lots of speakers, Road gear, Furniture, African masks, Kudu horns, long horns, Asian screens, vtg Brunswick Centennial pool table (dismantled), Much more! Photos @ DOGWOODESTATESALES.COM

Other Areas

CHATTANOOGA 3217 Joselin Lane 6/1 and 6/2 7:30-3:00. Name brand clothes, sterling silver/gold jwlry, tools, makeup

FARM EQUIPMENT AUCTION
58 East Stinson Rd. Lafayette, TN
Fri. June 8th, 9AM C.S.T
Farmer Sell Out, Selling on Site, Late model equip., 7% Buyers Premium
Ben Bray Real Estate & Auction Com. 615-666-2232

Assorted Merch
all kinds of things...

General Merchandise

BR suite, w/hutch etc. red oak. 1 pine & 1 poplar suite, fin & unfin at Furniture Shop, 3575 Buffalo Rd, Summertown

Code Annotated, Section 4-5-201 et. seq. and will take place in the 13th Floor Conference Room B of William R. Snodgrass Tennessee Tower, 312 Rosa L. Parks Avenue, Nashville, Tennessee, 37243 at 9:30 a.m. on the 25th day of June, 2018. Written comments will be included in the hearing records if received by the close of business 3rd day of July, 2018, at the office of the Technical Secretary, Tennessee Air Pollution Control Board, William R. Snodgrass Tennessee Tower 15th Floor, 312 Rosa L. Parks Avenue, Nashville, Tennessee 37243-1531. Any individuals with disabilities who wish to participate in these proceedings (or to review these filings) should contact the Tennessee Department of Environment and Conservation to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be in person, by writing, telephone, or other means, and should be made no less than ten (10) days prior to the 25th day of June, 2018, or the date such party intends to review such filings, to allow time to provide such aid or service. Contact the Tennessee Department of Environment and Conservation ADA Coordinator, 2nd Floor, William R. Snodgrass Tennessee Tower, 312 Rosa L. Parks Avenue, Nashville, Tennessee 37243. Hearing impaired callers may use the Tennessee Relay Service (1-800-848-0298). If you have any questions about the origination of these revisions, you may contact Dr. Jason Stephens at (615) 532-0584. Copies of documents concerning this matter are available for review at the office of the Technical Secretary and at certain public depositories. For information about reviewing these documents, please contact Mr. Malcolm Butler, 15th Floor, William R. Snodgrass Tennessee Tower, 312 Rosa L. Parks Avenue, Nashville, Tennessee 37243, telephone (615) 532-0600. The document may also be viewed/down-loaded from the TDEC public participation web site: https://www.tn.gov/environment/ppo-public-participation/ppo-public-participation/ppo-air.html. [Public Notice, Draft TN Ambient Air Monitoring Plan 2018 and Draft Local Programs Ambient Air Monitoring Plan 2018]

Summary of Proposed Revisions

The Tennessee Division of Air Pollution Control's ambient air monitoring plan specifies the number and type of ambient air stations that will be operate in Tennessee. An evaluation of the Division's plan is required by federal regulation at Code of Federal Regulations, Title 40, Chapter 1, Subchapter C, Part 58, Subpart B, and Paragraph 58.10. These regulations also specify the minimum number and types of ambient air monitors to be operated in the state. Revisions considered at this hearing will be submitted to the U.S. Environmental Protection Agency Region 4 Administrator. All persons interested in Ambient Air Monitoring Plan in the State of Tennessee are urged to attend and will be afforded the opportunity to present testimony to the hearing officer regarding the revisions to the States Ambient Air Monitoring Plan. Any person desiring to present lengthy comments should be prepared at the hearing to offer a written statement to be incorporated into the record. Written statements not presented at the hearings will only be considered part of the records if received by 4:30 p.m. 3rd day of July, 2018, at the office of the Technical Secretary, Tennessee Air Pollution Control Board, 15th Floor, William R. Snodgrass Tennessee Tower, 312 Rosa L. Parks Avenue, Nashville, Tennessee, 37243.

TN-00011729642

0002945412

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Cumberland Behavioral Health, LLC ("Applicant"), 300 Great Circle Road, Nashville (Davidson County), TN 37228, with the Applicant having an ownership type of limited liability company and owned by Saint Thomas Health and Acadia Nashville JV Holdings, LLC, and to be managed by Acadia Management Company, LLC, intends to file a Certificate of Need application for the construction, development and establishment of a new psychiatric hospital comprising a total of seventy-six (76) beds, forty (40) of which will provide services for adult patients plus thirty-six (36) of which will provide services for geriatric patients. This new hospital will be located at 300 Great Circle Road, Nashville (Davidson County), TN 37228. If this project is approved and licensed, Saint Thomas West will close its twenty-four (24) bed psychiatric unit and those beds will be voluntarily surrendered, resulting in a net increase of only fifty-two (52) new hospital beds. The proposed beds in this application will be licensed by the Tennessee Department of Mental Health and Substance Abuse Services as hospital beds. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. The estimated project cost is anticipated to be approximately $32,216,800.00, which includes a $95,000.00 filing fee.

The anticipated date of filing the application is: June 05, 2018.
The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at Anderson & Baker, 2021 Richard Jones Road, Suite 120, Nashville, TN 37215, 615/370-3380.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
500 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

Mr. Graham Baker, Jr., Attorney
Anderson and Baker
2120 Richard Jones Road
Nashville, TN 37215

RE: **Certificate of Need Application – Cumberland Behavioral Health- CN1806-022**

The establishment of a 76-bed mental health hospital to be located at 300 Great Circle Road, Nashville (Davidson County), TN. The hospital will contain 40 adult inpatient psychiatric beds and 36 geriatric inpatient psychiatric beds. If approved, St. Thomas West Hospital will close its 24-bed psychiatric unit, surrendering the beds. The applicant is owned by Cumberland Behavioral Health, LLC. The members and percentage of ownership are St. Thomas Health (50.1%) and Acadia Nashville JV Holdings, LLC (49.9%). The estimated project cost is $32,216,800.

Dear Mr. Baker:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Laura Young at the Tennessee Department of Mental Health and Substance Abuse Services for Certificate of Need review by the Division of Hospital Services. You may be contacted by Ms. Young or someone from her office for additional clarification while the application is under review by the Department. Ms. Young's contact information is Laura.Young@tn.gov or 615-741-7694.

In accordance with Tennessee Code Annotated, §68-11-1607, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project began on August 1, 2018. The first 60 days of the cycle are assigned to the Department of Mental Health and Substance Abuse Services, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on October 24, 2018.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

- All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Laura Young, DNP APN, FPMHNP-BC

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Laura Young, Chief Nursing Officer
Division of Hospital Services
TN Department of Mental Health and Substance Abuse Services
Andrew Jackson Building, 6th Floor
500 Deaderick Street
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: August 1, 2018

RE: Certificate of Need Application
Cumberland Behavioral Health - CN1806-022

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on August 1, 2018 and end on October 1, 2018.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Graham Baker

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Nashville Tennessean which is a newspaper of general circulation in Davidson County, Tennessee, on or before June 01, 2018, for one day.

==========

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that Cumberland Behavioral Health, LLC ("Applicant"), 300 Great Circle Road, Nashville (Davidson County), TN 37228, with the Applicant having an ownership type of limited liability company and owned by Saint Thomas Health and Acadia Nashville JV Holdings, LLC, and to be managed by Acadia Management Company, LLC, intends to file a Certificate of Need application for the construction, development and establishment of a new psychiatric hospital comprising a total of seventy-six (76) beds, forty (40) of which will provide services for adult patients plus thirty-six (36) of which will provide services for geriatric patients. This new hospital will be located at 300 Great Circle Road, Nashville (Davidson County), TN 37228. If this project is approved and licensed, Saint Thomas West will close its twenty-four (24) bed psychiatric unit and those beds will be voluntarily surrendered, resulting in a net increase of only fifty-two (52) new hospital beds. The proposed beds in this application will be licensed by the Tennessee Department of Mental Health and Substance Abuse Services as hospital beds. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. The estimated project cost is anticipated to be approximately $32,216,800.00, which includes a $95,000.00 filing fee.

The anticipated date of filing the application is: June 05, 2018.

The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at Anderson & Baker, 2021 Richard Jones Road, Suite 120, Nashville, TN 37215, 615/370-3380.

E. Graham Baker, Jr. (Signature) 06/01/2018 (Date) graham@grahambaker.net (E-mail Address)

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

Supplemental #1 (Original)

Cumberland Behavioral Health, LLC

CN1806-022

ANDERSON & BAKER
An Association of Attorneys
2021 RICHARD JONES ROAD, SUITE 120
NASHVILLE, TENNESSEE 37215-2874

ROBERT A. ANDERSON
Direct: 615-383-3332
Facsimile: 615-383-3480

E. GRAHAM BAKER, JR.
Direct: 615-370-3380
Facsimile: 615-221-0080

June 27, 2018

Mark A. Farber, Deputy Director
State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Hand-Delivered

Re: Certificate of Need Application CN1801-003
Regional One Extended Care Hospital
Supplemental Responses 2

Dear Mr. Farber:

Please find attached the Applicant's responses to your second set of Supplemental Questions. Please contract me if you have any additional questions.

Sincerely,

E. Graham Baker, Jr.

Encl: As Noted

Supplemental #1
June 27, 2018
11:31 A.M.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: Cumberland Behavioral Health, LLC, CN1806-022

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.

E. Graham Baker, Jr.
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 27th day of June, 2018, witness my hand at office in the County of Davidson, State of Tennessee.

N. Kathleen Baker
NOTARY PUBLIC

N. Kathleen Baker
State of Tennessee Notary Public
Davidson County

My commission expires JULY 05, 2021.

HF-0043

Revised 7/02

Cumberland Behavioral Health, LLC
CN1806-022

1. Section A, Executive Summary, A. Overview

What type of outpatient, intensive outpatient, and partial hospitalization programs are associated with this proposed project?

Response: Cumberland Behavioral Health will provide both intensive outpatient and partial hospitalization programs for its patients and the community. The programs will operate in compliance with Medicare requirements. Programs will be tailored to the patient populations served.

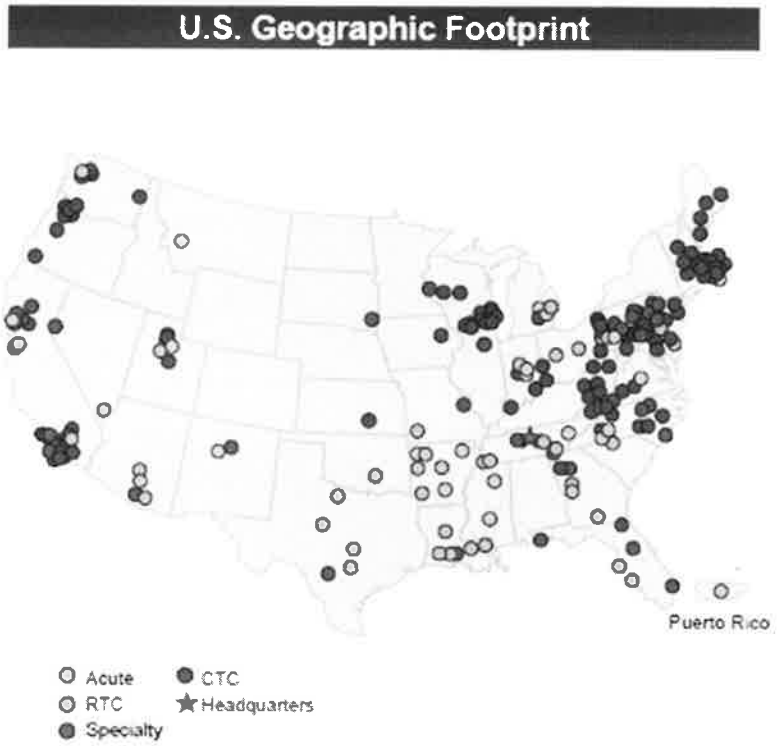
Please clarify if the proposed 76 bed inpatient mental health hospital will be classified as an Institution for Mental Disease (IMD).

Response: Cumberland Behavioral Health will meet the Federal definition for an Institution for Mental Disease (IMD).

Please describe the applicant's experience in operating the following:
Adult Inpatient Adult Psychiatric and Chemical Dependency Units
A Geriatric Inpatient Psychiatric Unit

Response: The applicants have extensive experience operating inpatient and outpatient psychiatric services. Saint Thomas Health operates a total of four inpatient behavioral health programs. The health system has a 10-bed unit at Saint Thomas Highlands Hospital in Sparta, which is in the process of expanding to 14 beds. Saint Thomas River Park Hospital operates a 10-bed unit, and Saint Thomas Stones River Hospital has a total of 22 behavioral health beds. In addition to the inpatient units at West, Stones River, Highlands, and River Park, Saint Thomas Hickman Hospital operates an intensive outpatient program in Centerville. Acadia Healthcare operates several adult, geriatric, and chemical dependency inpatient and outpatient programs in Tennessee. The Acadia Healthcare Tennessee facilities include Crestwyn Behavioral Health Hospital (Memphis), Delta Medical Center (Memphis), TrustPoint Hospital (Murfreesboro), Erlanger Behavioral Health Hospital (newly licensed June 2018 - Chattanooga), Villages Behavioral Health (non-acute adolescent residential program - Louisville), and Mirror Lake Recover Center (non-acute adult residential program - Burns). Additionally, Acadia Healthcare operates hundreds of psychiatric hospitals and treatment programs across the United States, United Kingdom, and Puerto Rico, making it a leading provider of inpatient and outpatient behavioral health services. Chart 1 (next page) illustrates the Acadia Healthcare behavioral health facility footprint across the United States and Puerto Rico.

Chart 1: Acadia Healthcare Facilities Across the United States and Puerto Rico



2. Section A, Executive Summary, B. Rationale for Approval

Please explain the difference between serious mental illness and severe mental illness.

Response: The terms "serious" and "severe" mental illness is used by the applicant to express the degree of disability and/or functional impairment resulting from mental illness. In this context, a patient with "serious" mental illness is defined as having a diagnosable mental illness that meets criteria specified within DSM–5, with symptoms that "substantially interfere with or limits one or more major life activities, which may include maintaining interpersonal relationships, activities of daily living, self-care, employment, and recreation" (Substance Abuse and Mental Health Services Administration, 2013, p.11). The patient with serious mental illness is expected to make substantial recovery with a return to pre-morbid functioning (i.e., return home and to work, family, activities of daily living, etc.). Patients with serious mental illness are more likely to suffer mood disorders, including depression, anxiety, and bipolar disorder. Patients with "severe" mental illness experience the same disabling and/or functional impairments of the patient with "serious" mental illness, except that their disease state may be more chronic, persistent, and treatment resistant. The patient with severe mental illness is more likely to suffer thought disorder including schizophrenia and other forms of psychosis. Patients with serious and severe mental disorders may have a primary or co-occurring substance use and abuse disorder.

Reference

Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). *Results from the 2012 National Survey on Drug Use and Health: Mental health findings* (NSDUH Series H-47, HHS Publication No. [SMA] 13-4805. Rockville, MD, Author

The Letter of Intent indicates that St. Thomas will surrender its 24 psychiatric beds if this project is approved, yet the discussion here states that St. Thomas West has not specified the intended use of these beds when vacated. Will St. Thomas West reduce its licensed bed complement by 24 beds, if this project is approved? Please discuss and provide clarification.

Response: STH intends to reduce its licensed bed count by 24 beds upon licensure of beds at the new facility.

Please provide the reports from TDMHSAS that supports the claim that 27,000 patients waiting in the emergency department with primary diagnosis of mental health waited more than 24 hours in 2015.

Response: Please see attached **Supplemental TDMHSAS**.

Does the applicant have similar statistics specific to St. Thomas West and/or St. Thomas Midtown?

Response: Preliminary data from Saint Thomas indicates the following: the number of psychiatric patients having to wait at Saint Thomas Midtown (STM below) and Saint Thomas West (STW below) emergency rooms were as follows:

Emergency Department Psychiatric Patients Wait Volume

Facility	2015	2016	2017
STM	2,004*	2,233	2,601
STW	1,288*	1,288	1,345
Total	3,292*	3,521	3,946

*Note: * 2015 totals were annualized, as exact figures were readily available for 3 months, only*

In addition, the wait times for those psychiatric patients were:

Emergency Department Psychiatric Patients Wait Time (hours)

Facility	2015	2016	2017
STM	5.04	5.07	4.99
STW	4.06	3.93	4.14
Total	9.1	9.0	9.13

Assuming the average wait time was 9 hours, for the 3 year period of 2015 – 2017, approximately 10,759 psychiatric patients waited in Saint Thomas Emergency Rooms for approximately 96,831 hours, which is over 4,035 days, or the equivalent of over 11 years.

Does the psychiatric unit at St. Thomas West only serve patients Age 65+?

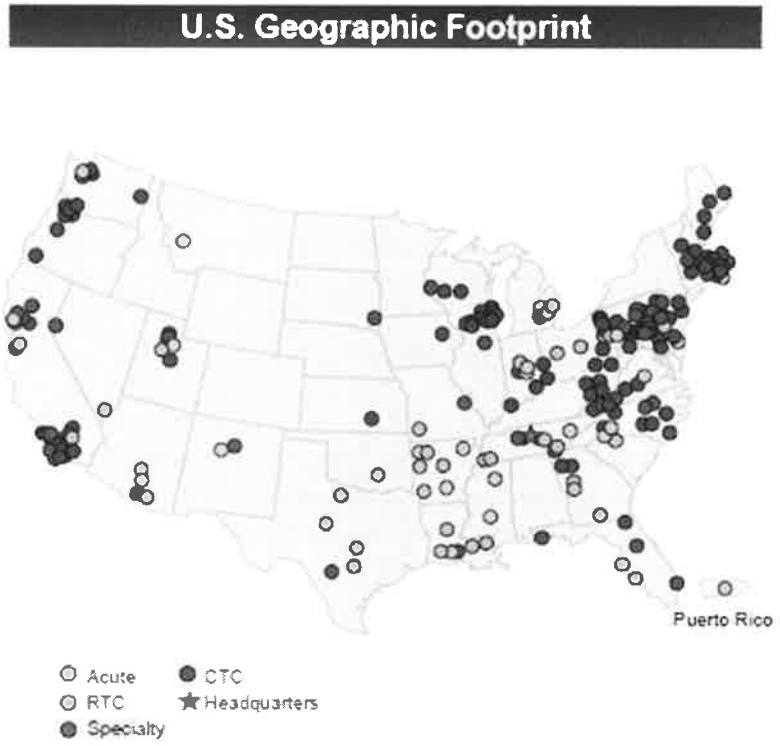
Response: The unit at Saint Thomas West serves patients age 55+ based on their clinical presentation. Joint Annual Reports for Saint Thomas West reports admissions and patient days for geriatric patients for years 2014, 2015, and 2016.

3. Section A, Project Details, Item 4.B (Ownership)

Please provide a general description of Acadia including a discussion of other health care institutions that Acadia has an ownership interest by type and their location by state.

Response: Acadia Healthcare operates several adult, geriatric, and chemical dependency inpatient and outpatient programs in Tennessee. The Acadia Healthcare Tennessee facilities include Crestwyn Behavioral Health Hospital (Memphis), Delta Medical Center (Memphis), TrustPoint Hospital (Murfreesboro), Erlanger Behavioral Health Hospital (newly licensed June 2018 - Chattanooga), Villages Behavioral Health (non-acute adolescent residential program - Louisville), and Mirror Lake Recover Center (non-acute adult residential program - Burns). Additionally, Acadia Healthcare operates hundreds of psychiatric hospitals and treatment programs across the United States, United Kingdom, and Puerto Rico, making it a leading provider of inpatient and outpatient behavioral health services. Chart 1 illustrates the Acadia Healthcare behavioral health facility footprint across the United States and Puerto Rico.

Chart 1: Acadia Healthcare Facilities Across the United States and Puerto Rico



Please also discuss St. Thomas Health's experience in psychiatric care and other psychiatric units/hospitals operated by St. Thomas Health.

Response: Saint Thomas Health operates a total of four inpatient behavioral health inpatient programs. The health system has a 10-bed unit at Saint Thomas Highlands Hospital in Sparta, which is in the process of expanding to 14 beds. Saint Thomas River Park Hospital operates a 10-bed unit, and Saint Thomas Stones River Hospital has a total of 22 behavioral health beds. In addition to the inpatient units at West, Stones River, Highlands, and River Park, Saint Thomas Hickman Hospital operates an intensive outpatient program in Centerville.

Please identify the members of Acadia Nashville JV Holdings, LLC and each member's percentage of ownership.

Response: Acadia JV Holdings, LLC – 100%

4. Section A, Project Details, Item 5 (Management/Operating Entity), Page 3

Please provide a brief overview of Acadia Management Company, LLC and their experience in managing inpatient adult/geriatric psychiatric hospitals.

Response: As stated previously, Acadia Healthcare and Acadia Management Company, LLC are industry leaders in the provision of mental health and substance abuse services across the United States, United Kingdom, and Puerto Rico. The company operates hundreds of hospitals and treatment centers providing mental health and substance abuse services to children, adolescents, adults, and geriatric patients.

Please identify the members of the LLC and each member's percentage of ownership.

Response: Acadia Healthcare Company, Inc. – 100%

5. Section A, Project Details, Item 6.A (Legal Interest in the Site) Page 4

Please provide a copy of the deed to the land from Sev Metrocenter IV, LLC to document its control of the land.

Response: See **Supplemental Special Warranty Deed**.

The "Purchase and Sales Agreement" does not include the effective date in March 2017. Did the applicant provide the $75,000 deposit to the Title Company?

Response: The effective date is March 29, 2017. The applicant did provide the $75,000 deposit to the Title Company. See **Supplemental Earnest Money**.

Please clarify the options of the due diligence and approval periods so that it is clear that the Option to Purchase agreement will remain in effect beyond the date that this application will be heard by the Agency.

Response: Please see **Supplemental Notice**. This is the notice of completion under the Purchase and Sale Agreement (**Attachment A.6.A.1**, already submitted) which states that the Approvals Period shall end on August 30, 2018 unless the Applicant extends under the Purchase and Sale Agreement. Under section 3.4 of the Purchase and Sale Agreement, the Applicant has the right to extend the Approvals Period for three successive periods of 30 days each (for up to 90 days total) by paying $15,000 for each extension. Therefore, extensions by the Applicant ensures that the agreement will remain in effect beyond the projected date of the hearing on this project.

6. Section A. Applicant Profile, Item I , 6B (2) Floor Plan,

Please confirm that the proposed mental health hospital will be a 2-story facility.

What is the square footage for each floor?

Response: The proposed mental health hospital will be a 2-story facility. The first floor of the proposed hospital will be 52,600 square feet, and the second floor will be 20,000 square feet. Please see **Supplemental Floor Footprints**, part of the original **Attachment A.6.B.2**.

7. **Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-)**

   The applicant is not using the current version of the CON criteria for inpatient psychiatric services.

   Please redo this section using the current version. The current version is available on the Agency's website.

Response: Please see **Supplemental Specific Criteria**.

Supplemental #1
June 27, 2018 Responses
11:31 A.M.

8. Section B. Need. Item C. Service Area,

In the Projected Utilization Chart what does the number of patients represent, e.g., admissions, unique patients, etc.? How can these numbers have decimal points?

Please complete the following Table for the most recent year available for St. Thomas West, ranked highest to lowest.

County	Admissions	% Total
Total		

Response: The chart at B.Need.Item C Service Area requests the number and percentage of total patients from each county of the proposed primary service area. Therefore, the numbers supplied are for the number and percentage of total patients from each county of the proposed primary service area. Our original projections were based on patient days. However, since this chart requests data to be supplied for "patients" – not "patient days" – we converted patient days to patients for this chart, as evidenced in the explanation below the chart on page 19.

Please complete the following Table for the most recent year available for St. Thomas West, ranked highest to lowest.

Response: The new requested table for Saint Thomas West is completed below, and the source of the data for this chart was the most current Joint Annual Report (2016) filed by Saint Thomas West for its hospital. Since only the "County" was requested, it was assumed that only Tennessee Counties were appropriate for inclusion in the chart. In fact, the JAR showed another 127 admissions from out of state. The percentages shown in the chart were rounded to the nearest tenth of a percent, and the individual county "% Total" will not add up to 100.0% due to rounding errors.

County	**Admissions**	**% Total**
Davidson	6103	35.4
Williamson	1166	6.8
Rutherford	863	5.0
Montgomery	762	4.4
Cheatham	672	3.9
Dickson	663	3.9
Sumner	595	3.5
Warren	571	3.3

Wilson	541	3.1
Coffee	345	2.0
Hickman	343	2.0
Henry	308	1.8
Robertson	247	1.4
Benton	243	1.4
Giles	242	1.4
Humphreys	240	1.4
Lawrence	237	1.4
Lincoln	234	1.4
Maury	232	1.3
Putnam	187	1.1
Franklin	182	1.1
Bedford	162	1.0
Smith	152	1.0
Marshall	139	0.9
DeKalb	133	0.8
White	127	0.7
Decatur	123	0.7
Macon	111	0.6
Perry	104	0.6
Stewart	103	0.6
Houston	100	0.6
Cannon	78	0.5
Wayne	73	0.4
Carroll	71	0.4
Weakley	67	0.4
Overton	55	0.3
Cumberland	54	0.3
Hamilton	47	0.3
Fentress	45	0.3
Grundy	43	0.2
Henderson	41	0.2
Hardin	36	0.2
Trousdale	30	0.2
Moore	29	0.2
Lewis	27	0.2
Jackson	22	0.1
Van Buren	19	0.1
Clay	18	0.1
Knox	18	0.1
Madison	17	0.1
Shelby	16	0.1
Obion	15	0.1
Gibson	14	0.1

Hamblin	11	0.1
Jefferson	10	0.1
McNairy	10	0.1
Rhea	10	0.1
Sullivan	10	0.1
Bradley	9	0.1
Pickett	9	0.1
Roane	7	<0.1
Blount	6	<0.1
Campbell	6	<0.1
McMinn	6	<0.1
Sequatchie	6	<0.1
Chester	5	<0.1
Greene	5	<0.1
Loudon	5	<0.1
Washington	5	<0.1
Sevier	4	<0.1
Anderson	3	<0.1
Cocke	3	<0.1
Hardeman	3	<0.1
Crockett	2	<0.1
Meigs	2	<0.1
Morgan	2	<0.1
Scott	2	<0.1
Claiborne	1	<0.1
Dyer	1	<0.1
Fayette	1	<0.1
Grainger	1	<0.1
Hawkins	1	<0.1
Haywood	1	<0.1
Marion	1	<0.1
Monroe	1	<0.1
Polk	1	<0.1
Tipton	1	<0.1
Bledsoe	0	0.0
Carter	0	0.0
Hancock	0	0.0
Johnson	0	0.0
Lake	0	0.0
Lauderdale	0	0.0
Unicoi	0	0.0
Union	0	0.0
Tennessee Total	17216	100.0

9. Section B. Need. Item D.1 Service Area Demographics

Please identify what years the applicant is using for current year and projected year.

Response: The current year is 2018 and the projected year is 2022.

The population figures originally utilized for the chart on page 22 of this application have been removed from the Tennessee Department of Health, Division of Policy, Planning and Assessment's website. Please note the State's new population chart showing projections from 2016 through 2030, a new chart placed on the website in May 2018.

The application's chart has been updated to reflect the new population data that was evidently changed last month. See Replacement page 22.

10. Section B, Need, Item E., Service Area Utilization

Please complete the following tables for service area inpatient psychiatric services

Total Inpatient Psychiatric Utilization Trends, 2014-2016

Hospital	Designated Beds (2016)	2014 Patient Days	2015 Patient Days	2016 Patient Days	'14- '16 % Change	2014 Occup. %	2015 Occup. %	2016 Occup. %
Middle TN MHI	300	64,670	66,218	63,585	-1.7	59.1	60.5	58.1
St. Thomas West	24	4,584	3,691	3,541	-22.8	52.3	42.1	40.4
TriStar Madison	105	26,006	23,697	23,925	-8.0	41.8	61.8	43.1
TriStar Centennial	109	32,900	26,288	24,345	-26.0	68.3	64.9	43.1
VUMC	88	28,258	27,324	27,520	-2.6	88.0	85.1	85.7
TOTAL	626	156,418	147,218	142,916	-8.6	68.5	64.4	62.5

Adult Inpatient Psychiatric Utilization Trends, 2014-2016

Hospital	2014 Admits	2015 Admits	2016 Admits	'14- '16 % Change	2014 Patient Days	2015 Patient Days	2016 Patient Days	'14- '16 % Change
Middle TN MHI	3,590	3,662	3,780	5.3	55,289	58,655	57,581	4.1
St. Thomas West	63	29	16	-74.6	987	568	471	-52.3
TriStar Madison	2,020	2,379	2,597	28.6	17,580	18,304	17,337	-1.4
TriStar Centennial	2,467	1,777	1,473	-40.3	21,227	17,760	15,188	-28.4
VUMC	2,484	2,568	2,656	6.9	17,960	17,334	19,386	7.9
TOTAL	10,624	10,415	10,522	-1.0	113,043	112,621	109,963	-2.7

Geriatric Inpatient Psychiatric Utilization Trends, 2014-2016

Hospital	2014 Admits	2015 Admits	2016 Admits	'14- '16 % Change	2014 Patient Days	2015 Patient Days	2016 Patient Days	'14- '16 % Change
Middle TN MHI	52	40	38	-27.0	9,381	7,531	6,004	-36.0
St. Thomas West	212	160	144	-32.1	3,597	3,123	3,070	-14.7
TriStar Madison	341	37	208	-39.0	3,950	437	1,919	-51.4
TriStar Centennial	785	583	558	-29.0	11,673	8,528	9,157	-21.6
VUMC	202	207	187	-7.4	2,388	2,113	1,365	-42.8
TOTAL	1,592	1,027	1,135	-28.7	30,989	21,732	21,515	-30.6

Adult + Geriatric Combined Inpatient Psychiatric Utilization Trends, 2014-2016

Hospital	2014 Admits	2015 Admits	2016 Admits	'14- '16 % Change	2014 Patient Days	2015 Patient Days	2016 Patient Days	'14- '16 % Change
Middle TN MHI	3,642	3,702	3,818	4.8	64,670	66,186	63,585	-1.7
St. Thomas West	275	189	160	-41.8	4,584	3,691	3,541	-22.8
TriStar Madison	2,361	2,416	2,805	18.8	21,530	18,741	19,256	-10.6
TriStar Centennial	3,252	2,360	2,031	-37.5	32,900	26,288	24,345	-26.0
VUMC	2,686	2,775	2,843	5.8	20,348	19,447	20,751	2.0
TOTAL	12,216	11,442	11,657	-4.6	144,032	134,353	131,478	-8.7

Response: Please see completed charts above, and notes on following page.

The Applicant believes the Joint Annual Reports, which served as the source for the previous charts, contain numerous errors. Those errors render the data in the charts unreliable.

For example, Saint Thomas West reported 22 licensed beds, but Licensure shows 24 beds at that facility. Further, TriStar Madison reported having 132 beds one year and 105 beds the other years. Licensure shows TriStar Madison as having 105 beds. In addition, TriStar Centennial reported 132 beds on one JARs, 152 beds on another JAR, but only 111 the remaining year. Licensure shows 109 beds for TriStar Centennial. Middle Tennessee Mental Health Institute has been staffing only 207 beds for several years, even though it is licensed for 300 beds. Obviously, these inconsistencies impact utilization and other factors requested in the preceding charts.

It is also noteworthy that both TriStar Madison and Vanderbilt University Medical Center reported having children and adolescent psychiatric beds, and the inclusion of that data is reflected in the first chart (Total Inpatient Psychiatric Utilization Trends, 2014-2016) on the top of the preceding page.

11. Section B, Need, Item F.

Please complete the following table:

Applicant's Projected Psychiatric Inpatient Utilization

Variable	2020	2021
Adult Psych Licensed Beds	40	40
Adult Psych. Admissions	710	1,331
Adult Psych. Pat. Days	5,223	9,793
Adult Psych. ALOS	7.4	7.4
Adult Psych. ADC	14.3	26.8
Adult Psych. % Lic. Occ.	36%	67%
Geriatric Psych. Licensed Beds	36	36
Geriatric Psych. Admissions	387	725
Geriatric Psych. Pat. Days	5,223	9,793
Geriatric Psych. ALOS	13.5	13.5
Geriatric Psych. ADC	14.3	26.8
Geriatric Psych % Lic. Occ.	40%	74%
Total Psych. Licensed Beds	76	76
Total Psych. Admissions	1,097	2,056
Total Psych. Pat. Days	10,446	19,586
Total Psych. ALOS	9.5	9.5
Total Psych. ADC	28.6	53.5
Total Psych. % Lic. Occ.	38%	70%

Response: Please see completed chart above.

12. Section B. Economic Feasibility Item D. (Projected Data Chart)

The Projected Data Chart is noted. However, there appears to be a calculation error for Total Non-Operating Expenses in Year 2 (2021)

If the applicant's owners are funding the project through cash reserves, please explain the annual capital expenditure costs.

What types of positions are included in Contract Labor?

Response: A typographical error was made in the input of year 2 (2021) Depreciation Expense. The correct amount is $1,099,487. With this correction, the Non-Operating Expenses calculate correctly. See Replacement page 32.

Capital expenditures represent repair and replacement spending on the building and equipment that is capitalized and depreciated under generally accepted accounting principles. Year 1 and 2 maintenance capital expenditures are projected at 1% of Net Revenue before Bad Debt based on our experience with similar projects.

Contract Labor includes pharmacy, lab and radiology services that will be purchased under long-term contracts as well as temporary staffing fees and professional fees for medical directors and consultants.

13. Section B. Economic Feasibility Item E. 3)

What is the source of the charge data for the other service area facilities?

What does the ** following St. Thomas West signify?

Response: The source for the charge data are Joint Annual Reports filed by the respective facilities for 2014, 2015, and 2016. A replacement page 37 is attached, which also repeats the explanation of the Saint Thomas West footnote again.

14. Section B, Economic Feasibility, Item F.3

Should Acadia's Capitalization Ratio be reported as 55.5%?

Response: Yes. That was a typographical error. Please see Replacement page 39.

15. **Section B, Economic Feasibility, Item G.**

The total gross revenue listed here is $18, 343, 0126 (sic). The gross revenue for Year 1 in the Projected Data Chart is $17,956,710.

Please address this discrepancy.

Response: There is no discrepancy as the two charts requested different information. The Projected Data Chart on page 32 is correct, as is the requested chart on page 40 of the application. Total Gross Revenue on the Projected Data Chart does not include Charity Care, since Charity Care is not a revenue source. However, the chart on page 40 did request Charity Care to be included (even though Charity Care is not a revenue source). The difference in the two figures ($386,317) is the Charity Care figure on the page 40 chart. That chart had a footnote stating as follows:

> "NOTE: Charity Care is normally recorded after contractual and administrative adjustments, but is included above to comply with the requested chart."

16. Section B, Economic Feasibility, Item H., Staffing,

If available, please identify and provide a CV for the medical director of the hospital. If this individual has not been selected yet, please identify the qualifications that would be required for the medical director position.

Response: The medical director for Cumberland Behavioral Health has not yet been selected. Minimum qualifications for Medical Director include:

- Physician licensed in the State of Tennessee to practice medicine
- Board Certification in Psychiatry
- Fellowship in addiction medicine preferred
- A minimum of 5 years clinical practice in an acute care psychiatric hospital setting
- Prior medico-administrative experience preferred
- Must pass all background screens and drug test
- Must meet medical staff credentialing requirements and requirements of the Joint Commission
- Position must be ratified by the Medical Executive Committee and Hospital Governing Board
- Physician must be of strong moral character, possess leadership skill and/or potential, and history of providing care that is safe, efficient, and highly reliable.

In Year 2 the applicant identifies $1,047,398 for physicians' salary and wages. Please identify FTE breakdown by physician specialty.

Response: In year 2, Cumberland Behavioral Health expects to directly employ a total of 3.6 – 4.0 psychiatrist FTEs for adult and geriatric psychiatry.

17. Section B, Quality Measures

Your response to this item is noted. Please address the following:

(p) For Inpatient Psychiatric projects:

1. Whether the applicant has demonstrated appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems and children who need quiet space; proper sleeping and bathing arrangements for all patients), adequate staffing (i.e., that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times), and how the proposed staffing plan will lead to quality care of the patient population served by the project;

Response: As a guiding principle, Cumberland Behavioral Health will provide care in the least restrictive environment for all patients. Care is planned and provided with the dignity and safety of the patient at the center of the treatment experience. Services will be exclusively provided to adult and geriatric patients. The facility design allows patients to have access off-unit to engage in social, recreational, and therapeutic groups and activities. Patients will dine in a spacious cafeteria unless their clinical condition requires tray service to their unit. Staffing is designed to ensure the constant presence, at all times, of registered nurses and behavioral health technicians. The treatment team is supplemented with Activity Therapists, Music Therapists, Licensed Social Workers, Psychologists, Registered Dieticians, Occupational and Physical Therapists, Nurse Practitioners, Drug and Alcohol Counselors, and such other professionals as may be needed to meet the unique needs of the patient population. This proposed staffing will provide patients with a clinically diverse and enriching program to promote recovery and return to normal living.

2. Whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems; and

Response: Cumberland Behavioral Health will engage a robust data collection, monitoring, reporting, and process improvement structure to identify and promote best practices, improve patient outcomes, and ensure safe and efficient care delivery that is compliant with state and federal regulatory requirements and Joint Commission standards. Among data collection and reporting activities, Cumberland Behavioral Health will collect and report the following types of quality data:

- CMS Core Measures
- HCAPHPS and HBIPS
- Hospital Inpatient Quality Reporting (CMS)
- Sentinel or Serious Safety Events
- Hospital Acquired Infections
- Antimicrobial Stewardship
- Internal Reporting of Improvement Initiatives and Outcomes

3. **Whether an applicant that owns or administers other psychiatric facilities has provided information on satisfactory surveys and quality improvement programs at those facilities.**

Response: Attached as **Supplemental Accreditation Reports** are the reports from the applicant for Tennessee facilities and programs providing inpatient and/or outpatient mental health services. Some of these reports are copies of supplemental information supplied to the HSDA on another application in March of this year. As such, many of the pages will already be stamped as supplemental responses.

18. Project Completion Forecast Chart

This application will not be heard by the Agency any sooner than October 2018. Please make the appropriate changes to the Project Completion Forecast Chart.

Response: Please see Replacement Page 55.

Demographic Variable/ Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population-Current Year	Total Population-Projected Year	Total Population-% Change	*Target Population-Current Year	*Target Population-Project Year	*Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Below Person Poverty Level	Below Person Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
Davidson Co	700384	729829	+4.2	545454	566722	+3.9	77.7	34.2	$50,484	110923	17.7	139472	21.8
Cheatham Co	40229	40795	+1.4	31497	32329	+2.6	79.2	40.2	$53,179	5045	12.9	7064	17.2
Robertson Co	70887	74156	+4.6	54036	568534	+5.2	76.7	38.5	$56,331	6960	10.5	11359	15.1
Service Area Total	811500	844780	+4.1	630987	655904	+3.9	77.6			122928		249268	25.8
State of TN Total	6769368	6992559	+3.3	5252692	5441378	+3.6	77.8	38.5	$46,574	1188730	17.7	1412063	20.5

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2018, then default Projected Year is 2022.*

NOTES on chart above: Bureau of the Census data is from 2016 (latest data). TennCare Enrollees, latest data, is from June, 2017, as are TennCare population figures. Population figures, both current year (2018) and projected year (2022) are from the new population chart on the Department of Health, Division of Policy, Planning and Assessment website.

Psychiatric problems affect all ages. However, for purposes of this question, the "Target Population" will include those aged 18 and over. The chart above reflects that assumption.

2) Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: All of Cheatham and Robertson Counties are medically underserved areas, according to Health Resources and Services Administration, as are many census tracts in Davidson County. The addition of more psychiatric beds in the service area will add more health care services and staff. See **Attachment B.Need.D.2** for a list of the MUA tracts in the three counties.

PROJECTED DATA CHART

☒ Total Facility ☐ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July (Month).

	Year 1 (2020)	Year 2 (2021)
A. Utilization Data (Specify unit of measure: **Average Daily Census**)	28.6	53.5
B. Revenue from Services to Patients		
1. Inpatient Services	$17,562,710	$33,671,867
2. Outpatient Services	384,000	928,000
3. Emergency Services		
4. Other Operating Revenue (Specify) **food services**	10,000	30,000
Gross Operating Revenue	**$17,956,710**	**$34,629,867**
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$9,332,936	$17,990,929
2. Provision for Charity Care	386,317	742,547
3. Provisions for Bad Debt	879,223	793,320
Total Deductions	$10,598,476	$19,526,795
NET OPERATING REVENUE	$7,358,234	$15,103,072
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care	1,621,841	2,990,396
b. Non-Patient Care	2,109,370	3,262,392
2. Physician's Salaries and Wages	633,420	1,047,398
3. Supplies	355,803	529,772
4. Rent		
a. Paid to Affiliates		
b. Paid to Non-Affiliates	24,000	24,720
5. Management Fees:		
a. Paid to Affiliates	294,329	604,123
b. Paid to Non-Affiliates		
6. Other Operating Expenses	3,072,506	4,451,411
Total Operating Expenses	$8,111,269	$12,910,212
E. **Earnings Before Interest, Taxes and Depreciation**	$(753,035)	$2,192,860
F. Non-Operating Expenses		
1. Taxes	$(478,172)	$284,277
2. Depreciation	1,086,089	1,099,488
3. Interest		
4. Other Non-Operating Expenses		
Total Non-Operating Expenses	$607,917	$1,383,765
NET INCOME (LOSS)	$(1,360,952)	$809,095

Chart Continues Onto Next Page

3) Compare the proposed charges to those of similar facilities in the service area or competing service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Our projected service area is primarily Davidson, Cheatham, and Robertson Counties, Tennessee. Below is a chart showing charges of the existing psychiatric facilities in our primary service area for 2016. The chart below reflects data provided by the various facilities on their respective Joint Annual Reports (JARs) for 2014, 2015, and 2016.

Select Financial Information

Psychiatric Facilities in Davidson County, 2016

Facility	Gross	Adj.	Net
Mid TN MHI	755	594	161
Saint Thomas West**	2587	1961	626
TriStar Madison	4969	4013	956
TriStar Parthenon	5057	4025	1032
Vanderbilt	2907	1919	988

NOTE: Gross = Gross Operating Revenue per Patient Day, Rounded Nearest Dollar
Adj. = Contractual Adjustments per Patient Day, Rounded Nearest Dollar
Net = Net Operating Revenue per Patient Day, Rounded Nearest Dollar

** The beds at Saint Thomas West will be surrendered if the instant CON application is approved. The Saint Thomas beds are all licensed as Geriatric, but the JARs report both Adult and Geriatric services.

The Applicant anticipates comparable figures to be $1,719, $1,015, and $704 in Year 1.

3) Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: [Long-term debt/(Long-term debt + Total Equity (Net assets)] x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

Response: The only long-term debt anticipated by the Applicant will be a $5M revolving line of credit from Acadia Healthcare Company, Inc., as lender, that will not be drawn upon until closer to opening as the entity begins incurring payroll and other operating expenses.

The Acadia party to the JV, Acadia Nashville JV Holdings, LLC, will have no debt.

Acadia Healthcare Company, Inc. has a Capitalization Ratio of 55.5% as of December 31, 2017.

Saint Thomas Health reports a Capitalization Ratio of 27.9%.

Supplemental #1
June 27, 2018
11:31 A.M.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1 below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		10/2018
2. Architectural and engineering contract signed	30	11/2018
3. Construction documents approved by the Tennessee Department of Mental Health and Substance Abuse Services	240	07/2019
4. Construction contract signed	60	09/2019
5. Building permit secured	60	11/2019
6. Site preparation completed	90	02/2020
7. Building construction commenced	1	02/2020
8. Construction 40% complete	210	09/2020
9. Construction 80% complete	210	04/2021
10. Construction 100% complete (approved for occupancy	130	08/2021
11. *Issuance of License	30	09/2021
12. *Issuance of Service	1	09/2021
13. Final Architectural Certification of Payment	1	09/2021
14. Final Project Report Form submitted (Form HR0055)	1	09/2021

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

The Joint Commission

Official Accreditation Report

Crestwyn Health Group LLC
9485 Crestwyn Hills
Memphis, TN 38125

Organization Identification Number: 590562

Initial Unannounced Full Event: 6/27/2016 - 6/29/2016

Report Contents

Executive Summary

Survey Analysis for Evaluating Risk (SAFER™)

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right.

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. *(Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.)* The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Supplemental #2
June 27, 2018
11:31 A.M.

Supplemental #1
March 27, 2018
11:42 am

Executive Summary

Program(s)	Survey Date(s)
Hospital Accreditation	06/27/2016-06/29/2016

Hospital Accreditation: As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Supplemental #2
June 27, 2018
11:31 A.M.

The Joint Commission

SAFER™ Matrix Description

Supplemental #1
March 27, 2018
11:42 am

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

All Evidence of Standards Compliance (ESC) forms, which outline corrective actions, will be due in 60 days. For those findings of a higher risk, two additional fields will be required within the ESC for the organization to provide a more detailed description of leadership involvement and preventive analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER Matrix Placement	Required Follow-Up Activity
LOW/LIMITED	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections
MODERATE/HIGH/LIMITED MODERATE/PATTERN HIGH/PATTERN	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections
[redacted]	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections • ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey
[redacted]	• 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections • ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey

Note: If an Immediate Threat to Health and Safety, also known as Immediate Threat to Life (ITL), is discovered during a survey, the organization immediately receives a preliminary denial of accreditation (PDA) and, within 72 hours, must either entirely eliminate that ITL or implement emergency interventions to abate the risk to patients (with a maximum of 23 days to totally eliminate the ITL). Please see the Accreditation Process Chapter within the Comprehensive Accreditation Manual for more information.

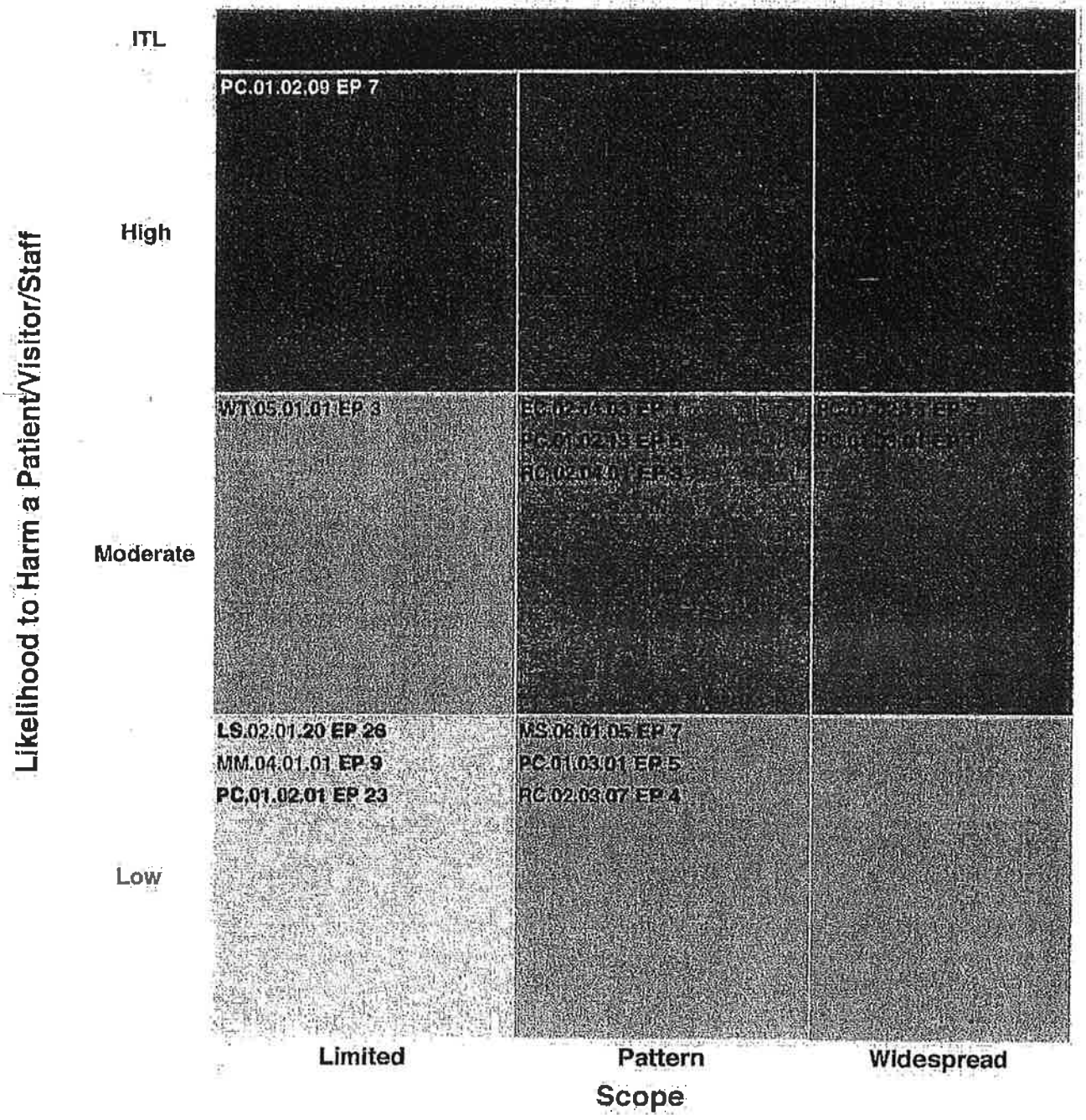
Supplemental #2
June 27, 2018
11:31 A.M.

The Joint Commission

SAFER Matrix

Supplemental #1
March 27, 2018
11:42 am

Hospital Accreditation Program



Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. *(Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.)* The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

The Joint Commission

Summary of CMS Findings

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(2)	A-0450	HAP - RC.02.03.07/EP4	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP1	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP26	Standard

CoP: §482.61 **Tag:** B103 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.61 Condition of Participation: Special medical record requirements for psychiatric hospitals.

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

CoP Standard	Tag	Corresponds to	Deficiency
§482.61(e)	B133	HAP - RC.02.04.01/EP3	Standard
§482.61(a)(5)	B109	HAP - PC.01.02.13/EP6	Standard
§482.61(b)(7)	B117	HAP - PC.01.02.13/EP2	Standard
§482.61(c)(1)	B119	HAP - PC.01.03.01/EP1	Standard
§482.61(c)(1)(ii)	B121	HAP - PC.01.03.01/EP5	Standard

CoP: §482.22 **Tag:** A-0338 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

Supplemental #2
June 27, 2018
11:31 A.M.

The Joint Commission

Summary of CMS Findings

Supplemental #1
March 27, 2018
11:42 am

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(1)	A-0340	HAP - MS.06.01.05/EP7	Standard

Requirements for Improvement – Detail

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.04.03

Standard Text: The hospital inspects, tests, and maintains medical equipment.

Element(s) of Performance:

1. For hospitals that do not use Joint Commission accreditation for deemed status purposes: Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)

For hospitals that use Joint Commission accreditation for deemed status purposes: Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)

Likelihood to Cause Harm: **Moderate**
Scope: **Pattern**

Observation(s):

EP 1
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:

Observed in Document Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.
During the document review and staff interview it was observed that the hospital did not perform safety, operational and functional checks before initial use for all of the hospital's medical equipment listed on the medical equipment inventory list. It was observed that the hospital started receiving their patients on May 2, 2016 and the documentation verified that the initial inspections of the medical equipment which includes but not limited to 3 AED devices were not conducted until June 2, 2016.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

26. In new buildings, no dead-end corridor is longer than 30 feet. (For full text and any exceptions, refer to NFPA 101-2000: 18.2.5.10)
Note: Existing dead-end corridors are permitted to be used if it is impractical and unfeasible to alter them. (For full text and any exceptions, refer to NFPA 101-2000: 19.2.5.10)

Likelihood to Cause Harm: Low
Scope : Limited

Observation(s):

EP 26
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.
During the building tour it was observed that the corridor near the dietary department and hazardous area room 1154 had a dead end corridor that was greater than 30 feet.

Chapter: Medical Staff
Program: Hospital Accreditation
Standard: MS.06.01.05
Standard Text: The decision to grant or deny a privilege(s), and/or to renew an existing privilege (s), is an objective, evidence-based process.

Element(s) of Performance:

7. The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

Likelihood to Cause Harm: Low
Scope : Pattern

Observation(s):

EP 7
§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.
This Standard is NOT MET as evidenced by:

Observed in Credentialing and Privileging at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.
In 2 of 3 medical staff/credentialing files reviewed, Radiologist chart's had the NPDB queried in 2014, but not before starting work for the hospital in May 2016

Chapter:	Medication Management
Program:	Hospital Accreditation
Standard:	MM.04.01.01
Standard Text:	Medication orders are clear and accurate.

Element(s) of Performance:

9. A diagnosis, condition, or indication for use exists for each medication ordered.
Note: This information can be anywhere in the medical record and need not be on the order itself. For example, it might be part of the medical history.

Likelihood to Cause Harm: **Low**
Scope: **Limited**

Observation(s):

EP 9

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site.
One record had multiple medications that did not have indications. The medications were Depakote and Geodon. The MD note did not explain the use of the medications.

Chapter:	Provision of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	PC.01.02.01

Standard Text: The hospital assesses and reassesses its patients.

Element(s) of Performance:

23. During patient assessments and reassessments, the hospital gathers the data and information it requires. (See also PC.01.01.01, EP 24)

Likelihood to Cause Harm: **Low**
Scope : **Limited**

Observation(s):

EP 23

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. One patient who scored low fall risk was not rescreened in one week according to directions on the form. However, the policy for fall risk does not address reassessments.

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. While the CAGE assessment had been done, the actual alcohol assessment had not been done. The patient was admitted 6/21/16 and the assessment should be done within 72 hours according to hospital policy.

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 10 patient records reviewed, of both open and closed medical records the section of the medical history and physical exam that addressed previous surgical procedures was left blank. It is likely that the patient, an adolescent, had not had any procedures in the past, however, that should have been indicated in the medical history and physical examination.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.09

Standard Text: The hospital assesses the patient who may be a victim of possible abuse and neglect.

Element(s) of Performance:

7. The hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. (See also RI.01.06.03, EP 3)

Likelihood to Cause Harm: **High**
Scope : **Limited**

Observation(s):

EP 7

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 1 patient records reviewed, closed medical record of a 17 year old adolescent who had been admitted for severe depression and melancholy in part related to her first sexual encounter which she related to care givers upon admission. The encounter had occurred, ostensibly, with a 25 year old man. There was no discussion in the medical record that the sexual molestation had been reported to the Division of Child Protective Services.

Chapter:	Provision of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	PC.01.02.13
Standard Text:	The hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.

Element(s) of Performance:

2. Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following:
- Current mental, emotional, and behavioral functioning
- Maladaptive or other behaviors that create a risk to the patient or others
- Mental status examination
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Reason for admission as stated by the patient and/or others significantly involved in the patient's care
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Onset of the patient's illness and circumstances leading to admission
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan (See also PC.01.03.01, EP 1)

Likelihood to Cause Harm: **Moderate**
Scope : **WideSpread**

6. Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:
- A psychiatric evaluation
- Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.01.02.03, EP 4)

Likelihood to Cause Harm: **Moderate**
Scope : **Pattern**

Observation(s):

EP 2
§482.61(b)(7) - (B117) - (7) Include an inventory of the patient's assets in descriptive, not interpretative, fashion.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the *Psychiatric Hospital deemed service.*
In 9 of 10 patient records reviewed, Both open and closed medical records reviewed the inventory of assets checked in the psychiatric evaluation did not give sufficient detail to determine how they should be used in treatment of the patient. The recreation therapist did detail activity preferences including games, television programs, sports in the activities interventions of the plan. However, these don't demonstrate the personal strengths as defined in the interpretive guidelines of conditions of participation: "..*although the term* strength is often used interchangeably with assets, only the assets which describe personal strengths on which to base the treatment plan or which are useful in therapy represent personal strengths. Strengths are personal attributes i.e. knowledge, skills, aptitudes, personal experiences, education, talents and employment status which may be useful in developing a meaningful treatment plan..."

EP 6
§482.61(a)(5) - (B109) - (5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.
This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the *Psychiatric Hospital deemed service.*
In 1 of 10 patient records reviewed, One of the 10 open and closed medical records reviewed had an incomplete neurological exam. The cranial nerve evaluation was not completed.

Standard Text: The hospital plans the patient's care.

Element(s) of Performance:

1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2; PC.01.02.13, EP 2)

Likelihood to Cause Harm: Moderate
Scope : WideSpread

5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals.

Likelihood to Cause Harm: Low
Scope : Pattern

Observation(s):

EP 1
§482.61(c)(1) - (B119) - (1) Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities.

The written plan must include—
This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.
In 9 of 10 patient records reviewed, Both open and closed it was evident that the treatment plan was not based on the inventory of the patient's strengths and disabilities. The selection of strengths and disabilities that is attached to the Master Treatment Plan is a check list and not further referenced in the goals established in the treatment plan. It also does not correlate with the inventory of strengths and disabilities of the checklist in the psychiatric evaluation. General statements such as "hobbies", "motivation", "talents" etc. should be followed with further detail of what each of those selections reference. Of note; the activities therapists do lists "likes" and "dislikes" in the treatment plans that include specific sports, activities, television etc.

EP 5
§482.61(c)(1)(ii) - (B121) - (ii) Short-term and long-range goals;
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.
In 3 of 6 patient records reviewed, There were goals that were not measurable. Examples include: "David will process life stressors contributing to depression." and "Pt will have alternative coping strategies that reinforce positive outcomes." "will be compliant with detox protocol."

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.02.03.07

Standard Text: Qualified staff receive and record verbal orders.

Element(s) of Performance:

4. Verbal orders are authenticated within the time frame specified by law and regulation.

Likelihood to Cause Harm: **Low**
Scope : **Pattern**

Observation(s):

EP 4
§482.24(c)(2) - (A-0450) - (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.
In 2 of 7 patient records reviewed, Verbal orders had not been signed within the 48 hours which was the hospital's policy. One telephone order contained 5 different medications and was given on 5/11/16 and was signed on 5/14/16. Another medication had been given on 6/23/15 and had not been signed by 6/27/16 during the survey.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.02.04.01

Standard Text: The hospital documents the patient's discharge information.

Element(s) of Performance:

3. In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following:
- The reason for hospitalization
- The procedures performed
- The care, treatment, and services provided
- The patient's condition and disposition at discharge
- Information provided to the patient and family
- Provisions for follow-up care

Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.

Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.

Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.

Likelihood to Cause Harm: **Moderate**
Scope : **Pattern**

Observation(s):

EP 3
§482.61(e) - (B133) - §482.61(e) Standard: Discharge planning and discharge summary.

The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and
This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.
In 3 of 3 patient records reviewed, All closed medical records that had a discharge summary and "Discharge Plan" there was a recapitulation of the patient's hospital course, however, none of the three contained a detail of the goals and specifically goal attainment.

Chapter:	Waived Testing
Program:	Hospital Accreditation
Standard:	WT.05.01.01
Standard Text:	The hospital maintains records for waived testing.

Element(s) of Performance:

3. Quantitative test result reports in the medical record for waived testing are accompanied by reference intervals (normal values) specific to the test method used and the population served.
Note 1: Semiquantitative results, such as urine macroscopic and urine dipsticks, are not required to comply with this element of performance.
Note 2: If the reference intervals (normal values) are not documented on the same page as and adjacent to the waived test result, they must be located elsewhere within the permanent medical record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the medical record.

Likelihood to Cause Harm: **Moderate**
Scope : **Limited**

Observation(s):

EP 3

**Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site.
In 1 of 1 patient records reviewed, Closed medical record of a very brittle diabetic patient it was noted that the reference ranges for the device used for point of care testing for blood glucose was not in the patient's medical record.**

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The Implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 0

Supplemental #1
June 27, 2018
11:31 A.M.

Supplemental #1
March 27, 2018
11:42 am

The Joint Commission

Official Accreditation Report

DMC - Memphis, Inc.
3000 Getwell Road
Memphis, TN 38118

Organization Identification Number: 7875

Unannounced Full Event: 12/1/2015 - 12/3/2015

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Executive Summary

Program(s)	Survey Date(s)
Hospital Accreditation Behavioral Health Care Accreditation	12/01/2015-12/03/2015

Hospital Accreditation :

As a result of the accreditation activity conducted on the above date(s), you have met the criteria for Accreditation with Follow-up Survey.

If your organization wishes to clarify any of the standards you believe were compliant at the time of survey, you may submit clarifying Evidence of Standards Compliance in 10 business days from the day this report is posted to your organization's extranet site.

You will have follow-up in the area(s) indicated below:

- As a result of a Condition Level Deficiency, an Unannounced Medicare Deficiency Follow-up Survey will occur. Please address and correct any Condition Level Deficiencies immediately, as the follow-up event addressing these deficiencies will occur within 45 days of the last survey date identified above. The follow-up event is in addition to the written Evidence of Standards Compliance response.
- Evidence of Standards Compliance (ESC)

Behavioral Health Care Accreditation :

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.05.01	EP15
	EC.02.05.09	EP1,EP3
	LS.02.01.20	EP1,EP13,EP31
	LS.02.01.34	EP2
	MS.03.01.01	EP2
	PC.01.02.08	EP1
	PC.02.01.11	EP2
	PC.04.01.05	EP8
Program:	Behavioral Health Care Accreditation Program	
Standards:	CTS.04.03.33	EP3
	NPSG.15.01.01	EP1

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP5
	EC.02.05.05	EP5
	EC.02.06.01	EP1,EP13

Supplemental #2
June 27, 2018
11:31 A.M.

The Joint Commission

Supplemental #1
March 27, 2018
11:42 am

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

	HR.01.02.05	EP1
	IC.02.01.01	EP1
	LD.01.03.01	EP2
	LS.02.01.10	EP3,EP5,EP9
	LS.02.01.30	EP11
	LS.02.01.35	EP5
	MM.03.01.01	EP2
	MS.01.01.01	EP3,EP16
	MS.08.01.03	EP2
	PC.01.02.13	EP2
	PI.02.01.01	EP4
	RC.01.01.01	EP19
Program:	Behavioral Health Care Accreditation Program	
Standards:	CTS.02.01.11	EP1
	CTS.03.01.01	EP1
	CTS.03.01.03	EP3

The Joint Commission
Summary of CMS Findings

CoP: §482.11 **Tag:** A-0020 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.11 Condition of Participation: Compliance with Federal, State and Local Laws

CoP Standard	Tag	Corresponds to	Deficiency
§482.11(c)	A-0023	HAP - HR.01.02.05/EP1	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Condition

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.02.01/EP5, EC.02.06.01/EP1	Standard
§482.41(b)(5)	A-0712	HAP - LS.02.01.30/EP11	Standard
§482.41(c)(2)	A-0724	HAP - EC.02.05.09/EP1, EP3	Standard
§482.41(c)(4)	A-0726	HAP - EC.02.06.01/EP13	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP3, EP5, EP9, LS.02.01.20/EP1, EP13, EP31, LS.02.01.30/EP11, LS.02.01.34/EP2, LS.02.01.35/EP5	Standard

CoP: §482.42 **Tag:** A-0747 **Deficiency:** Standard

Corresponds to: HAP - IC.02.01.01/EP1, EC.02.05.01/EP15

The Joint Commission
Summary of CMS Findings

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP: §482.21 **Tag:** A-0263 **Deficiency:** Standard

Corresponds to: HAP - PI.02.01.01/EP4

Text: §482.21 Condition of Participation: Quality Assessment and Performance Improvement Program

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

CoP: §482.12 **Tag:** A-0043 **Deficiency:** Condition

Corresponds to: HAP - LD.01.03.01/EP2

Text: §482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

CoP Standard	Tag	Corresponds to	Deficiency
§482.12(a)(4)	A-0048	HAP - MS.01.01.01/EP3	Standard

CoP: §482.22 **Tag:** A-0338 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(1)	A-0340	HAP - MS.03.01.01/EP2, MS.06.01.03/EP2	Standard
§482.22(c)(5)(i)	A-0358	HAP - MS.01.01.01/EP16	Standard

Requirements for Improvement – Detail

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.02.01 ESC 60 days
Standard Text: The hospital manages risks related to hazardous materials and waste.
Element(s) of Performance:

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 5
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed in the Surgery decontamination room that the eyewash station that was an unapproved two step unit that required turning on the faucet and then pressing a bypass valve on the spout to initiate water flow. The unit was require due to the use of Prolystica and Surgistain which both required a 15 minute flush in the SDS information. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed in the old ICU dialysis area on the 2nd floor that there was no eyewash station. The unit was require due to the use liquid chlorine bleach which required a 15 minute flush in the SDS information. This was verified by the Director of Plant Operations.

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.05.01 ESC 45 days
Standard Text: The hospital manages risks associated with its utility systems.

Element(s) of Performance:

15. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies. (See also EC.02.06.01, EP 13)
Note: Areas designed for control of airborne contaminants include spaces such as operating rooms, special procedure rooms, delivery rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis), patients in 'protective environment' rooms (for example, those receiving bone marrow transplants), laboratories, pharmacies, and sterile supply rooms. For further information, see Guidelines for Design and Construction of Health Care Facilities, 2010 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 15
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Standard is NOT MET as evidenced by:
Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that in the Surgery area that the clean sterile room was negative to the decontamination room. This was identified on a Test and Balance report on 5/11/15 and not corrected. This was verified by the Director of Plant Operations. This was corrected during the survey by tightening the belt on the supply unit and verifying the proper test & balance.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that in the Surgery area that the clean storage room was negative to the corridor. This was identified on a Test and Balance report on 5/11/15 and not corrected. This was verified by the Director of Plant Operations. This was corrected during the survey by tightening up the belt on the supply unit and verified by test & balance.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that in the Surgery area that the sub-sterile room between OR #3 & OR #4 was positive to both OR's. This was verified by the Director of Plant Operations. This was corrected during the survey by tightening up the belt on the exhaust fan and verifying the test & balance.

Supplemental #2
June 27, 2018
11:31 A.M.

The Joint Commission

Supplemental #1
March 27, 2018
11:42 am

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.05.05 ESC 60 days
Standard Text: The hospital inspects, tests, and maintains utility systems.
Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.

Element(s) of Performance:

5. The hospital inspects, tests, and maintains the following: Non–high-risk utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2 and 4)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 5
Observed in Individual Tracer at DMC - Memphis, Inc. I 3000 Getwell Road, Memphis, TN (Main) (3000 Getwell Road, Memphis, TN) site.
Observed in Document Review at DMC - Memphis, Inc. (3000 Getwell Road,Memphis,TN) site.
It was observed that smoke and fire testing was done on 9/25/15 and that no repairs to failed dampers had been done as of 12/2/15. This was verified by the Director of Plant Operations.

Observed in Document Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
It was observed that smoke and fire testing was done on 9/25/15 and that no repairs to failed dampers had been done as of 12/2/15. This was verified by the Director of Plant Operations.

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.05.09 ESC 45 days
Standard Text: The hospital inspects, tests, and maintains medical gas and vacuum systems.
Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

The Joint Commission

Element(s) of Performance:

1. In time frames defined by the hospital, the hospital inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented. (See also EC.02.05.01, EP 3)

Scoring Category : A
Score : Insufficient Compliance

3. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that in the Medical Gas testing report dated 10/23/15 that PACU had no alarm panel or vacuum zone valve and that Surgery had no functioning alarm lights for medical air and vacuum. Surgery also had no audible alarm sounds for any gases. In review of the testing report from 10/24/14 that the same deficiencies had been identified and that a proposal had been given for their repair. There had been no repairs to these deficiencies since 2014. This was verified by the Director of Plant Operations.

EP 3
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
During tour of the surgical suite, it was noted that storage carts and shelving located along wall in the main corridor of the operating room were blocking access to the medical gas shutoff valves located behind them.

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.06.01

ESC 60 days

Standard Text: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

Scoring Category : C
Score : Insufficient Compliance

13. The hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided. (See also EC.02.05.01, EP 15)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
During tour of the surgical suite and evaluation of the process for decontamination of GI endoscopes, it was noted that the storage cabinet for the clean endoscopes was blocking access to an electrical panel in the operating room.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed in Operating room #1 that the electrical panel was blocked by a C-arm and other equipment. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed in Operating room #2 that the electrical panel was locked and OR staff did not have a key to access to be able to reset a circuit breaker. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that in the Operating Room #1 that there were 2 blue multi outlet power taps that were daisy chained with a white multi power tap that was installed on an anesthesia machine. One of the units was clamped to the anesthesia machine and another to a roll around pole with a bair hugger plugged into it which pulled 9.5 amps. The units are UL1363A and rated at 15 amps. The units had multiple other pieces of equipment plugged into them and open available outlets that could used to plug in other devices. They were not part of a tested assembly.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that in the Operating Room #2 that there was a blue multi outlet power tap that was clamped to a roll around pole with a bair hugger plugged into it which pulled 9.5 amps. The unit is UL1363A and rated at 15 amps. The unit had multiple other pieces of equipment plugged into it and open available outlets that could used to plug in other devices. It was not part of a tested assembly.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that in the Operating Room #3 that there was a blue multi outlet power tap that was clamped to a roll around pole with a bair hugger plugged into it which pulled 9.5 amps. The unit is UL1363A and rated at 15 amps. The unit had multiple other pieces of equipment plugged into it and open available outlets that could used to plug in other devices. It was not part of a tested assembly.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that in the Operating Room #1 that there were twist lock to standard pronged plug extension cord adapters that were used to power equipment that were not on the Biomedical equipment list as tested assemblies. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that in the Operating Room #3 that there were twist lock to standard pronged plug extension cord adapters that were used to power equipment that were not on the Biomedical equipment list as tested assemblies. This was verified by the Director of Plant Operations.

EP 13
§482.41(c)(4) - (A-0726) - (4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.
This Standard is NOT MET as evidenced by:

The Joint Commission

Supplemental #1
March 27, 2018
11:42 am

Observed In Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that on the 4th floor nursing unit that the clean utility room was negative to the corridor. This was verified by the Director of Plant Operations.

Observed In Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that on the 4th floor nursing unit that the clean linen room was negative to the corridor. This was verified by the Director of Plant Operations

Observed In Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that on the 2nd floor medical/surgical unit that the clean supply room was negative to the corridor. This was verified by the Director of Plant Operations

Observed In Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed on the 2-West Psych unit that the soiled utility room was positive to the corridor when it should have been negative. This was verified by the Director of Plant Operations.

Chapter:	Human Resources
Program:	Hospital Accreditation
Standard:	HR.01.02.05
Standard Text:	The hospital verifies staff qualifications.

ESC 60 days

Element(s) of Performance:

1. When law or regulation requires care providers to be currently licensed, certified, or registered to practice their professions, the hospital both verifies these credentials with the primary source and documents this verification when a provider is hired and when his or her credentials are renewed. (See also HR.01.02.07, EP 2)
Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented.
Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source.
Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.11(c) - (A-0023) - (c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.
This Standard is NOT MET as evidenced by:
Observed in Competency Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
There was a lack of documentation to demonstrate verification of the dietician's license with the primary source at the time of license renewal. The dietician's license expired 9/30/2014 but was verified with the primary source 8/18/2015. (Note: There was no lapse in licensure.)

Chapter: Infection Prevention and Control
Program: Hospital Accreditation
Standard: IC.02.01.01 ESC 60 days
Standard Text: The hospital implements its infection prevention and control plan.

Element(s) of Performance:

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
Dual diagnosis unit: The shower curtain in a patient's bathroom was visibly contaminated with black mold.

Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
Mental health unit 1: A 2nd shower curtain in a patient's bathroom was visibly contaminated with black mold.

Chapter: Leadership
Program: Hospital Accreditation
Standard: LD.01.03.01 ESC 60 days
Standard Text: The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Element(s) of Performance:

2. The governing body provides for organization management and planning.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.12 - (A-0043) - §482.12 Condition of Participation: Condition of Participation: Governing Body
This Condition is NOT MET as evidenced by:
Observed in Auto Score for CLD at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews:§482.41 - (A-0700), §482.12 - (A-0043)

Supplemental #2
June 27, 2018
11:31 A.M.

The Joint Commission

Supplemental #1
March 27, 2018
12:06 pm

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10 ESC 60 days

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Element(s) of Performance:

3. Walls that are fire rated for 2 hours (such as common walls between buildings and occupancy separation walls within buildings) extend from the floor slab to the floor or roof slab above and extend from exterior wall to exterior wall. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.2.2)

Scoring Category : A
Score : Insufficient Compliance

5. Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1-11.4)

Scoring Category : C
Score : Insufficient Compliance

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 3
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed on the 4th floor nursing unit that the 1 hour smoke/fire wall was not sealed properly to the deck above patient room #413. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed on the 4th floor nursing unit that the 1 hour smoke/fire wall was not sealed properly to the deck above patient room #418. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that at the old ICU - Dialysis unit that above the 11/2 hour fire doors that the 2 hour fire wall was not sealed to the deck. This was verified by the Director of Plant Operations.

EP 5
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed on the 2nd floor near the old ICU dialysis unit that the cross corridor fire doors in the two hour fire wall did not latch when allowed to close due to a faulty coordinator. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that at the old ICU - Dialysis unit that the 11/2 hour fire doors in the 2 hour fire wall had the latching hardware removed and were being held shut with a magnetic lock system. It was evident by the plates on the door where the hardware used to be. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that at the old ICU - Dialysis unit that the 11/2 hour fire doors in the 2 hour fire wall had the latching hardware removed and were being held shut with a magnetic lock system. It was evident by the plates on the door where the hardware used to be. This was verified by the Director of Plant Operations.

EP 9
§482.41(b)(1)(i) - (A-0710) - (I) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed on the 2nd floor medical/surgical unit that the 1 hour smoke/fire wall was had 3 medical gas pipes that were not sealed properly above patient room #267. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed on the 2nd floor medical/surgical unit that the 1 hour smoke/fire wall was had a 1/2 inch and a 3/4 inch conduit that had open ends that were not sealed properly above patient room #267. This was verified by the Director of Plant Operations

Chapter:	Life Safety
Program:	Hospital Accreditation
Standard:	LS.02.01.20 (ESC 45 days)
Standard Text:	The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

1. Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4)

Scoring Category : A
Score : Insufficient Compliance

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)

Scoring Category : C
Score : Insufficient Compliance

31. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high (or 6 inches high if externally lit). (For full text and any exceptions, refer to NFPA 101-2000: 7.10.1.2, 7.10.5, 7.10.6.1, and 7.10.7.1)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
§482.41(b)(1)(i) - (A-0710) - (I) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that the Surgery main entrance cross corridor doors had a slide bolt on one door and a padlock on the other door that were locked at night to secure the area. This made egress through these doors impossible even though they were a marked exit path. The locks were removed during the survey.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that at the marked exit doors leading out of the 2nd floor old ICU dialysis unit that they were magnetic locked and did not release when traveling in the egress direction unless you pushed an exit button located 9 feet away from the doors. There was no proximity sensor that allowed you to egress. They were connected to the fire alarm system and would release on fire alarm. This was verified by the Director of Plant Operations.

EP 13
§482.41(b)(1)(i) - (A-0710) - (I) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed in the Surgery area exit corridor that was unsprinkled that there was a linen cart and a storage shelf that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed in the Surgery area exit corridor that was unsprinkled that there was a microscope and a Stryker supply cart that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed in the Surgery area exit corridor that was unsprinkled that there was a supply cart, two multi -drawer cabinets and an H tank on wheels that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed on the 2nd floor medical/surgical unit that the exit corridor had a computer on wheels that was plugged in, two blood pressure machines and two linen carts located in the hall near patients rooms 257 and 263 that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

EP 31
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed on the 2nd floor Geri Psych unit that the day room needed an exit sign over the second exit door. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed on the 2-West Psych unit that there were four (4) exit signs needed over the control doors in the corridor to identify the exit path. This was verified by the Director of Plant Operations.

The Joint Commission

Program: Hospital Accreditation

Standard: LS.02.01.30

ESC 60 days

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Element(s) of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.
Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door.
(For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category : C
Score : *Partial Compliance*

Observation(s):

EP 11
§482.41(b)(1)(i) - (A-0710) - (I) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
§482.41(b)(5) - (A-0712) - (5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospitals.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that the door to the Surgery decontamination room that opened to the exit corridor did not latch and was equipped with a door closer. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. I 3000 Getwell Road, Memphis, TN (Main) (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed in the Surgery area that the unsprinkled corridor door to Pre-op holding removed and had been fitted with a self closer and door latch. The door on to PACU on the opposite side of the hall still retained its door with self closer and door latch. This was verified by the Director of Plant Operations.

Chapter: Life Safety
Program: Hospital Accreditation
Standard: LS.02.01.34 ESC 45 days
Standard Text: The hospital provides and maintains fire alarm systems.
Element(s) of Performance:

2. The master fire alarm control panel is located in a protected environment (an area enclosed with 1-hour fire-rated walls and 3/4-hour fire-rated doors) that is continuously occupied or in an area with a smoke detector. (See also LS.02.01.10, EP 5) (For full text and any exceptions, refer to NFPA 101-2000: 9.6.4 and NFPA 72-1999: 1-5.6 and 3-8.4.1.3.3)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed that the Edwards fire panel was located behind the main desk area which was open to the lobby and did not have a smoke detector protecting it. This was verified by the Director of Plant Operations.

Chapter: Life Safety
Program: Hospital Accreditation
Standard: LS.02.01.35 ESC 60 days
Standard Text: The hospital provides and maintains systems for extinguishing fires.

Supplemental #2
June 27, 2018
11:31 A.M.

Supplemental #1
March 27, 2018
11:42 am

Element(s) of Performance:

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 5
§482.41(b)(1)(i) - (A-0710) - (I) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed in the front lobby area that there were two dirty sprinkler heads in front of the main desk. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
It was observed in the front meeting that there were two dirty sprinkler heads above the front window. This was verified by the Director of Plant Operations.

Chapter: Medical Staff
Program: Hospital Accreditation
Standard: MS.01.01.01 ESC 60 days
Standard Text: Medical staff bylaws address self-governance and accountability to the governing body.

Element(s) of Performance:

3. Every requirement set forth in Elements of Performance 12 through 36 is in the medical staff bylaws. These requirements may have associated details, some of which may be extensive; such details may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated. Adoption of associated details that reside in medical staff bylaws cannot be delegated. For those Elements of Performance 12 through 36 that require a process, the medical staff bylaws include at a minimum the basic steps, as determined by the organized medical staff and approved by the governing body, required for implementation of the requirement. The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (See the 'Leadership' (LD) chapter for requirements regarding the governing body's authority and conflict management processes.)
Note: If an organization is found to be out of compliance with this Element of Performance, the citation will occur at the appropriate Element(s) of Performance 12 through 36.

Scoring Category : A
Score : Insufficient Compliance

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. (For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6-11.)
Note 1: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
Note 2: The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 and 5.

Scoring Category : A
Score : Insufficient Compliance

The Joint Commission

Observation(s):

EP 3
§482.12(a)(4) - (A-0048) - [The governing body must:]

(4) Approve medical staff bylaws and other medical staff rules and regulations;
This Standard is NOT MET as evidenced by:
Observed in Regulatory Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
In review of medical staff bylaws it was noted that compliance with element of performance 16 in this standard was not met because the process for completing and documenting medical history and physical examinations was not described in sufficient detail to satisfy CoP 482.22 (c) (5) (i) - (A-0358)

EP 16
§482.22(c)(5)(i) - (A-0358) - (i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
This Standard is NOT MET as evidenced by:
Observed in Regulatory Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
The requirements for completing and documenting medical history and physical examination were not described in detail sufficient to specify exactly who may perform H&P's and required updates, the time frames involved, and the requirement for countersignature when applicable. The statement relating to H&P in the Bylaws simply referenced the related section in the medical staff Rules and Regulations.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.03.01.01 ESC 45 days

Standard Text: The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

Element(s) of Performance:

2. Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

Scoring Category: A
Score: Insufficient Compliance

Observation(s):

EP 2
§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.
This Standard is NOT MET as evidenced by:
Observed in Record Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
The record of a patient who had undergone an operation by a podiatric surgeon under general anesthesia was reviewed. The record contained a preoperative H&P that had been documented by the podiatrist. During the credentialing session, it was confirmed that podiatrists at this hospital did not have privileges to perform H&Ps. In providing this service to this patient, this podiatrist was practicing outside the scope of his privileges as determined by the organized medical staff. The podiatrist was appropriately licensed and had been credentialed and privileged by the medical staff to perform the surgical procedure.

Observed in Record Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
On review of a second record of a patient who presented for a podiatric surgical procedure under anesthesia, it was noted that the H&P had been performed and documented by a nurse anesthetist. On review of the credentials file of a nurse anesthetist, it was noted that the specific privilege of performing general medical histories and physical examinations had not been granted to nurse anesthetists. The anesthetist had been granted specific privileges for performing examinations necessary to determine preanesthesia risk assessments, but not for a full medical H&P that would count as an admission H&P for other medical purposes. In performing the complete admission H&P for this podiatric patient, the anesthetist was practicing outside the scope of his privileges as determined by the medical staff.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.08.01.03 ESC 60 days

Standard Text: Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

Element(s) of Performance:

2. The process for the ongoing professional practice evaluation includes the following: The type of data to be collected is determined by individual departments and approved by the organized medical staff.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.
This Standard is NOT MET as evidenced by:
Observed in Medical Management Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
During tracer activity, record review, and subsequent discussion with medical staff members at the credentialing and privileging session, it was learned that a nurse anesthetist was independently performing pain management procedures utilizing lumbar epidural steroid injections. On review of the credentials file for this anesthetist, there was no documentation of a request from the anesthetist to perform this specific procedure, a procedure which was outside the scope of the privileges originally granted to him. The medical staff and anesthesia department had not proactively developed a process for monitoring this procedure by an anesthetist and had not determined the type of data to be collected for assessment. At the time of his most recent reappointment, there was no notation of the number of procedures he had done or the outcomes from the interventions during the pervious appointment cycle. This was the only anesthetist at the hospital performing lumbar epidural steroid injections.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.03.01.01 — EXC 60 days

Standard Text: The hospital safely stores medications.

Element(s) of Performance:

2. The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.
Note: This element of performance is also applicable to sample medications.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 2
Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
During tracer activity on the Med-Surg unit it was noted that the documentation for the temperature in the medication refrigerator attached to the automated dispensing system was missing for November 29th. Hospital policy required daily documentation of refrigerator temperature to assure consistency of function.

Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
Senior care unit: Temperatures were not continuously monitored in the dormitory style refrigerator that stored a box of influenza vaccines. Staff checked the refrigerator temperature once daily. The refrigerator was also observed to have a large amount of frost and ice formation.

Chapter: *Performance Improvement*

Program: Hospital Accreditation

Standard: PI.02.01.01

ESC 60 days

Standard Text: The hospital compiles and analyzes data.

Element(s) of Performance:

4. The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

4

Scoring Category: A
Score: Insufficient Compliance

Observation(s):

EP 4
§482.21 - (A-0263) - §482.21 Condition of Participation: Condition of Participation: Quality Assessment and Performance Improvement Program
This Standard is NOT MET as evidenced by:
Observed in Data Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
While the hospital collected a large amount of data, there was no data analysis performed over time to identify variance in performance. There was a lack of evidence the hospital aggregated, analyzed, and compared internal data to identify patterns, trends, and variations over time. The hospital provided lists and spreadsheets of raw data including falls; restraints; elopement; harm to staff and patients; and hand hygiene compliance.

Chapter: *Provision of Care, Treatment, and Services*

The Joint Commission

Program: Hospital Accreditation

Standard: PC.01.02.08 ESC 45 days

Standard Text: The hospital assesses and manages the patient's risks for falls.

Element(s) of Performance:

1. The hospital assesses the patient's risk for falls based on the patient population and setting. 3

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
**Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
Senior Care unit: An initial assessment to determine the patient's risk for falls was not documented as required by the organization's policy #NSG 02-42: "Fall precaution assessment and rating". The patient was admitted to the hospital 11/18 but the first documented assessment for risk for falls was entered at 1916 on 11/19.**

**Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
An initial assessment to determine the patient's risk for falls was not documented as required by the organization's policy #NSG 02-42: "Fall precaution assessment and rating". The patient was admitted to the hospital 11/21 at 0630 but the first documented assessment for risk for falls was entered 11/22 at 1617.**

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.13 ESC 60 days

Standard Text: The hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.

Element(s) of Performance:

2. Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following:
- Current mental, emotional, and behavioral functioning
- Maladaptive or other behaviors that create a risk to the patient or others
- Mental status examination
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Reason for admission as stated by the patient and/or others significantly involved in the patient's care
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Onset of the patient's illness and circumstances leading to admission
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan (See also PC.01.03.01; EP 1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
For a patient's initial multidisciplinary treatment plan, there was a lack of a psychiatrist's signature by name and title. The organization's policy #BH 02-09: "Treatment planning" required those participating in the development of the treatment plan to sign the plan by name and title. (Note: This was obtained as a late entry on the last day of survey activities.)

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.02.01.11 ESC 45 days
Standard Text: Resuscitation services are available throughout the hospital.

Element(s) of Performance:

2. Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. Senior care unit: On 12/1/2015, the time of day displayed/printed on the defibrillator/monitor on the emergency resuscitation cart was incorrect. The time displayed/printed was 1605 but the actual time of day was 1430. The unit director reported the defibrillator/monitor tape was retained for documentation in the patient's medical record. (The time of day was observed to be corrected on site 12/2.)

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.04.01.05 ESC 45 days
Standard Text: Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, and services.

Element(s) of Performance:

8. The hospital provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand. (See also RI.01.01.03, EP 1)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 8
Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
For a patient that received procedural sedation (ketamine and propofol) in the ED, the written discharge instructions lacked instructions specific to the sedation received.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
For a patient that received procedural sedation (versed) in the ED, the written discharge instructions lacked instructions specific to the sedation received.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01 EBC 60 days

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
The record of a patient who underwent placement of a dialysis catheter under anesthesia was reviewed. The surgeon had not dated or timed his authentication mark on the document for informed consent.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.
The practitioner's pre-procedural ECT orders and post-procedural ECT note lacked documentation of date and/or time.

The Joint Commission

Chapter: Care, Treatment, and Services
Program: Behavioral Health Care Accreditation
Standard: CTS.02.01.11 ESC 60 days

Standard Text: The organization screens all individuals served for their nutritional status. Note: Triggers for a nutritional assessment may include a weight loss or weight gain of 10 pounds or more in the past three months, a change in appetite, dental problems, noncompliance with a special diet, and food allergies. (Refer to CTS.02.03.09, EP 1 for more information)

Element(s) of Performance:

1. The organization screens all individuals served to identify those for whom a nutritional assessment is indicated.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. There was no process to screen individuals served in the partial hospitalization process to identify those for whom a nutritional assessment was indicated. When asked, the nurse said that that this was not a part of the assessment process. This patient was not screened.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. There was no process to screen individuals served in the partial hospitalization process to identify those for whom a nutritional assessment was indicated. When asked, the nurse said that that this was not a part of the assessment process. This patient was not screened.

Chapter: Care, Treatment, and Services
Program: Behavioral Health Care Accreditation
Standard: CTS.03.01.01 ESC 60 days

The Joint Commission

Standard Text: The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served.
Note: For opioid treatment programs: Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and the liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.

Element(s) of Performance:

1. The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and are used in the plan for care, treatment, or services.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The patient had several needs that were identified in the assessments and that he described in talking with him. These included finding a place to live where he could live with a roommate and returning to school to complete his education. However, they were not used in the treatment plan. The treatment plan included only the diagnoses.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The patient had several needs that were identified in the assessments and that he described in talking with him. In particular, he was interested in developing supportive relationships and being an outstanding grandfather. However, these needs and goals were were not used in the treatment plan. The treatment plan included only the diagnoses.

Chapter: Care, Treatment, and Services
Program: Behavioral Health Care Accreditation
Standard: CTS.03.01.03 ESC 30 days
Standard Text: The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

Supplemental #2
June 27, 2018
11:31 A.M.

The Joint Commission

Supplemental #1
March 27, 2018
11:42 am

Element(s) of Performance:

3. The objectives of the plan for care, treatment, or services meet the following criteria:
- They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3)
- They are sufficiently specific to assess the progress of the individual served
- They are expressed in terms that provide indices of progress

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 3
Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
The objectives in the treatment plan did not include identified steps to achieve the goal and were not written in terms that were sufficiently precise to permit assessing the progress of the client.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
The objectives in the treatment plan did not include identified steps to achieve the goal and were not written in terms that were sufficiently precise to permit assessing the progress of the client.

Chapter: Care, Treatment, and Services
Program: Behavioral Health Care Accreditation
Standard: CTS.04.03.33

Standard Text: For organizations providing food services: The organization has a process for preparing and/or distributing food and nutrition products.

Element(s) of Performance:

3. For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
**Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
The partial hospitalization program stored food and beverages used by patients in a refrigerator. There was a process to ensure that the proper temperature was maintained. However, it was ineffective. The designated temperature range was 33 to 40 degrees. The recorded temperature for 4 of the last 30 days had been out of range and no action had been taken. The current temperature on the thermometer in the refrigerator was out of range.**

Chapter: National Patient Safety Goals
Program: Behavioral Health Care Accreditation
Standard: NPSG.15.01.01 ESC 45 days
Standard Text: Identify individuals at risk for suicide.
Element(s) of Performance:

1. Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
**Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
The patient had been admitted with recent suicidal ideation and a suicide plan. There was no suicide risk assessment that included individual factors that both increase and decrease the risk of suicide.**

**Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.
The patient had been admitted with recent suicidal ideation. There was no suicide risk assessment that included individual factors that both increase and decrease the risk of suicide.**

The Joint Commission

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program:	Hospital Accreditation Program	
Standards:	HR.01.04.01	EP4
	HR.01.06.01	EP5
	LS.02.01.30	EP2,EP23
	MM.04.01.01	EP13
	MM.05.01.01	EP11
	NPSG.15.01.01	EP1
	PI.02.01.01	EP1
	RC.02.01.03	EP7
Program:	Behavioral Health Care Accreditation Program	
Standards:	CTS.02.02.01	EP1

Opportunities for Improvement – Detail

Chapter: Human Resources
Program: Hospital Accreditation
Standard: HR.01.04.01
Standard Text: The hospital provides orientation to staff.

Element(s) of Performance:

4. The hospital orients staff on the following: Their specific job duties, including those related to infection prevention and control and assessing and managing pain. Completion of this orientation is documented. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7; IC.02.04.01, EP 2; RI.01.01.01, EP 8)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP4
Observed in Competency Session at DMC - Memphis, Inc. (3000 Getwell Road,Memphis,TN) site.
For the infection preventionist, there was a lack of documentation of orientation specific to the role and job duties of the infection preventionist.

Chapter: Human Resources
Program: Hospital Accreditation
Standard: HR.01.06.01
Standard Text: Staff are competent to perform their responsibilities.

Element(s) of Performance:

5. Staff competence is initially assessed and documented as part of orientation.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP5
Observed in Competency Session at DMC - Memphis, Inc. (3000 Getwell Road,Memphis,TN) site.
For the infection preventionist, there was a lack of documented evidence that an initial assessment of competency was completed specific to the role of the infection preventionist.

Supplemental #2
June 27, 2018
11:31 A.M.

The Joint Commission
Findings

Supplemental #1
March 27, 2018
11:42 am

Chapter:	Life Safety
Program:	Hospital Accreditation
Standard:	LS.02.01.30
Standard Text:	The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Element(s) of Performance:

2. All hazardous areas are protected by walls and doors in accordance with NFPA 101-2000: 18/19.3.2.1. (See also LS.02.01.10, EP 5; LS.02.01.20, EP 18) Hazardous areas include, but are not limited, to the following:
Boiler/fuel-fired heater rooms
- Existing boiler/fuel-fired heater rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New boiler/fuel-fired heater rooms have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
Central/bulk laundries larger than 100 square feet
- Existing central/bulk laundries larger than 100 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laundries have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New central/bulk laundries larger than 100 square feet have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
Flammable liquid storage rooms (See NFPA 30-1996:4-4.2.1 and 4-4.4.2)
- Existing flammable liquid storage rooms have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
- New flammable liquid storage rooms have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
Laboratories (See NFPA 45-1996 to determine if a laboratory is a 'severe hazard' area)
- Existing laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laboratories have walls fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- Existing laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. When there is a sprinkler system, the walls are fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- Existing flammable gas storage rooms in laboratories have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)

- New flammable gas storage rooms in laboratories have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99 -1999: 10-10.2.2)

Maintenance repair shops

- Existing maintenance repair shops have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with at least 3/4-hour fire-rated doors.
- New maintenance repair shops have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Piped oxygen tank supply rooms (See NFPA 99-1999: 4-3.1.1.2)

- Existing piped oxygen tank supply rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New piped oxygen tank supply rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Paint shops that are not severe hazard areas

- Existing paint shops that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New paint shops that are not severe hazard areas have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Soiled linen rooms

- Existing soiled linen rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New soiled linen rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Storage rooms

- Existing storage rooms for combustible materials larger than 50 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire -rated doors.
- New storage rooms for combustible materials 50 to 100 square feet are sprinklered, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- New storage rooms for combustible materials larger than 100 square feet are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Trash collection rooms

- Existing trash collection rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices;

or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New trash collection rooms are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Scoring Category : C
Score : Satisfactory Compliance

23. Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. Doors do not have nonrated protective plates more than 48 inches above the bottom of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.5, 18/19.3.7.6, and 8.3.4.1)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road,Memphis,TN) site.
It was observed on the 2nd floor old ICU dialysis unit that a patient room had been converted into a hazardous storage room. The room was un-sprinkled and was approximately 160 square feet. The door was not self-closing and did not latch. There were 4 wooden pallets of cardboard boxed supplies stored there. This was verified by the Director of Plant Operations.
EP23
Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road,Memphis,TN) site.
It was observed that the back door to Dietary that was in a 1 hour smoke wall and was equipped with a closer and latching hardware did not latch. This was verified by the Director of Engineering.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.04.01.01
Standard Text: Medication orders are clear and accurate.

Element(s) of Performance:

13. The hospital implements its policies for medication orders.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP13
Observed in Record Review at DMC - Memphis, Inc. (3000 Getwell Road,Memphis,TN) site.
The record of a patient who underwent a surgical procedure by a podiatrist was reviewed. In the post operative orders, the podiatrist had written "resume all pre op meds". This order was not deemed acceptable by hospital pharmacy policy.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.05.01.01

Standard Text: A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

Element(s) of Performance:

11. After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing. 3

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP11
Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road,Memphis,TN) site.
During tracer activity on the Med-Surg unit, the record of a patient who had undergone an orthopedic procedure the previous day was reviewed. The physician had ordered both Dilaudid and Morphine "for pain". Both orders had been reviewed by the pharmacist and were active in the MAR. The physician had not specified the pain level to prompt intervention or the sequence in which the two therapeutic options should be utilized. The questions had not been clarified with the prescriber by the pharmacist before entering the orders into the MAR.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.15.01.01

Standard Text: Identify patients at risk for suicide.
Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Element(s) of Performance:

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide. 3

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

The Joint Commission
Findings

EP1
Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road,Memphis,TN) site.
For a patient admitted to the Dual Diagnosis unit, the patient's risk for suicide was not accurately assessed as required by the organization's policy. The patient's risk was scored 17 (defined by the organization as low risk) but not accurately documented as 27 (defined by the organization as moderate risk). The organization's policy #02-38: Suicide risk assessment" required staff to complete the initial suicide risk assessment as part of the initial admission assessment.

Chapter: Performance Improvement
Program: Hospital Accreditation
Standard: PI.02.01.01
Standard Text: The hospital compiles and analyzes data.

Element(s) of Performance:

1. The hospital compiles data in usable formats.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP1
Observed in Data Session at DMC - Memphis, Inc. (3000 Getwell Road,Memphis,TN) site.
There was a lack of evidence the hospital compiled data in usable formats. Data such as; falls, restraints, elopement, episodes of harm to staff and patients, and hand hygiene compliance were presented as raw data in lists and spreadsheets.

Chapter: Record of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: RC.02.01.03
Standard Text: The patient's medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.

Supplemental #2
June 27, 2018
11:31 A.M.

The Joint Commission
Findings

Supplemental #1
March 27, 2018
11:42 am

Element(s) of Performance:

7. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP7
Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road,Memphis,TN) site. During tracer activity on the Med-Surg unit, the record of a patient who had undergone an orthopedic operation the previous day was reviewed. No documentation of an immediate post procedure progress note could be located. A full operative note had been dictated by the surgeon later in the day and subsequently transcribed that evening. However, there was no concurrent note in the record to provide information which may have been required by caregivers during that time interval.

Chapter: Care, Treatment, and Services
Program: Behavioral Health Care Accreditation
Standard: CTS.02.02.01
Standard Text: The organization collects assessment data on each individual served.

Element(s) of Performance:

1. As relevant to care, treatment, or services, the organization collects the following assessment data about each individual served:
- Environment and living situation(s)
- Leisure and recreational interests
- Religion or spiritual orientation
- Cultural preferences
- Childhood history
- Military service history, if applicable
- Financial issues
- Usual social, peer-group, and environmental setting(s)
- Language preference and language(s) spoken
- Ability to self-care
- Family circumstances, including bereavement
- Current and past trauma
- Community resources accessed by the individual served

Note 1: Relevance to care, treatment, or services may be determined by the individual's presenting needs and the organization's scope of care, treatment, or services.

Note 2: For certain populations, early identification of community resources is important to care, treatment, or services. Such populations include individuals with severe mental illness or disabilities and children and youth. Community resources for these groups encompass a wide range of services. These services are supportive (such as community mental health, sheltered living, day treatment, or activity programs) as well as commonly accessed by the general public (such as public transportation, banking, or retail stores). For youth or children in foster care or in-home services, resources might include community mental health centers, teen centers, YMCAs, or Jewish community centers. These sources of community services may be used as informational, discharge planning, supportive, or continuing care resources.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP1
Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road,Memphis,TN) site.
There was a process for completing a psychosocial assessment. However, for these patient, it was not followed. A very brief assessment had been done with only a few items. The person who completed the assessment stated that when a patient is transferred from another hospital, as this patient was, this is the policy. When asked for the policy, it could not be found. There was no completed psychosocial assessment of updated psychosocial assessment for this patient.

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 1

Site:	DMC - Memphis, Inc.
Building Name:	Delta Medical Center_HAP
PFI Id:	DMC1501
Description:	
Sprinkler piping supporting other items	
ILSM Access:	No
Projected Completion Date:	12/10/2016
Funds Committed:	No
Accepted Date:	12/3/2015

Supplemental #1
June 27, 2018
11:31 A.M.

305

Supplemental #2
March 29, 2018
11:59 A.M.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440159	A. BUILDING 02 - BUILDING B. WING	01/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA MEDICAL CENTER	3000 GETWELL RD MEMPHIS, TN 38118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 082	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation on 1/14/13, it was determined that the facility failed to maintain sprinkler heads. The findings included: During the facility tour on 1/14/13, on the 3rd floor in room 306 ballroom a sprinkler head was wrapped with a clear plastic preventing the operation of the sprinkler head. This floor is unoccupied and the rooms are being used for storage. These rooms are not secured. The findings were acknowledged by the Administrator at the exit interview.	K 082	1) The plan of correcting the specific deficiency cited. The plan should address the processes that lead to the deficiency cited. -The plastic was removed from the sprinkler head, and rooms used for storage have had locks installed. 2) The procedure for implementing the acceptable plan of corrections for the specific deficiency cited. -Security will check the storage rooms daily to make sure they remain locked and there is no improper usage. 3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. -Security will log rounds on a daily basis. Any deficiencies will be addressed accordingly. 4) The title of the person responsible for implementing the acceptable plan of correction. -Neil Gaines (Director of Plant Ops) will ensure compliance.	01/14/2013
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 6.4.4.1.	K 144		

accepted 2-12-13 QS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: CEO | (X6) DATE: 2/4/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Supplemental #1
June 27, 2018
11:31 A.M.

Supplemental #2
March 29, 2018
11:59 A.M.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X5) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440159	A. BUILDING 02 - BUILDING B. WING	01/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA MEDICAL CENTER	3580 GETWELL RD MEMPHIS, TN 38118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	CMS COMPLETION DATE
K 144	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to maintain the emergency generator in accordance with National Fire Protection Association (NFPA) 110, Chapter 6.4.2. The findings included: Observations of the generator annunciator on 1/14/13, located in the emergency room, revealed that the annunciator panel showed a low fuel alarm, a common fault alarm, and the alarm on the panel had been silenced. The findings were acknowledge by the Administrator at the exit interview on 1/14/13.	K 144	1) The plan of correcting the specific deficiency cited. The plan should address the processes that lead to the deficiency cited. -The generator was/had 1/2 fuel tank level on the morning of 01/14/2013 during the weekly run. The generator was refueled and the alarm cleared. -ED staff will be educated on correct reporting procedures. 2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited. -ED staff will be trained to report any alarm on the annunciator panel to the Plant Operations Department. 3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. -The training will be added to the ED staff orientation inventory. 4) The title of the person responsible for implementing the acceptable plan of correction. -Mike Shackelford (Director of ED) will ensure compliance.	01/14/2013 01/28/2013
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation on 1/14/13, it was determined the facility failed to maintain night lights in 16 of 18 patient rooms. The findings included: During the facility tour on 1/14/13, there were 18 patient rooms on the 4th floor that did not have night lights operating. The findings were acknowledge by the Administrator at the exit interview on 1/14/13.	K 147	1) The plan of correcting the specific deficiency cited. The plan should address the processes that lead to the deficiency cited. -Bulbs were replaced in all night lights. 2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited. -Night lights in patient rooms will be checked monthly with all other emergency lighting. Also, the Charge Nurse may report any outages via the work order system at any time. 3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. -A log of the lighting checks will be kept in Plant Operations. 4) The title of the person responsible for implementing the acceptable plan of correction. -Neal Gaines (Director of Plant Ops) will ensure compliance.	01/14/2013

Supplemental #2 1
June 27, 2018
11:31 A.M.

307

Supplemental #2
March 29, 2018
11:59 A.M.

PRINTED: 01/17/2013
FORM APPROVED
Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN#031108	A. BUILDING: 02 - BUILDING B. WING _____	01/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA MEDICAL CENTER	3000 GETWELL RD MEMPHIS, TN 38118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1408	1200-8-1-.14 (2)(a)4. Disaster Preparedness (2) Physical Facility and Community Emergency Plans. (a) Physical Facility (Internal Situations). 4. Drills of the disaster preparedness plan shall be conducted at least once a year. The risk focus may vary by type of drill. Drills are for the purpose of educating staff, resource determination, testing personal safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years. This Rule is not met as evidenced by: Based on record review on 1/14/13, it was determined the facility failed to conduct disaster drills. The findings included: During the facility record review, the facility did not have records of tornado, bomb, flood, and earthquake drills.	H1408	1) How the deficiency will be corrected. Drills will be conducted at least once a year with the focus varying from tornado, bomb, flood, and earthquake. 2) How the facility will prevent the same deficiency from recurring. A schedule will be created for the drills. 3) The date the deficiency will be corrected. 4) How ongoing compliance will be monitored. Critiques and disaster logs will be generated for each drill. 5) The title of the person responsible for implementing the acceptable plan of correction. Neal Gaines (Director of Plant Ops) will ensure compliance.	02/17/2013

Division of Health Care Facilities

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM 6899 00BO21 If continuation sheet 1 of 1

Supplemental #21
June 27, 2018
11:31 A.M.

The Joint Commission

Official Accreditation Report

Saint Thomas Highlands Hospital, LLC
401 Sewell Road
Sparta, TN 38583

Organization Identification Number: 7909

Unannounced Medicare Deficiency Survey: 11/3/2017 - 11/3/2017

Report Contents

Executive Summary

Survey Analysis for Evaluating Risk (SAFER™)

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right.

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process (*Please note, if your survey event resulted in a Preliminary Denial of Accreditation status, other follow-up events may apply*). The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Executive Summary

Program(s)	Survey Date(s)
Hospital Accreditation	11/03/2017-11/03/2017

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission
SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice, and has the potential to impact only one or a very limited number of patients, visitors, staff
- Pattern: multiple occurrences of the deficiency, or a single occurrence that has the potential to impact more than a limited number of patients, visitors, staff
- Widespread: deficiency is pervasive in the facility, or represents systemic failure, or has the potential to impact most/all patients, visitors, staff

All Evidence of Standards Compliance (ESC) forms, which outline corrective actions, will be due in 60 days *(Please note, if your survey event resulted in a Preliminary Denial of Accreditation status, other follow-up events may apply)*. For those findings of a higher risk, two additional fields will be required within the ESC for the organization to provide a more detailed description of leadership involvement and preventive analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED, HIGH/PATTERN, HIGH/WIDESPREAD	• **60 day Evidence of Standards Compliance (ESC)** • **Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC** • **Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review**
MODERATE/PATTERN, MODERATE/WIDESPREAD	• **60 day Evidence of Standards Compliance (ESC)** • **Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC** • **Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review**
MODERATE/LIMITED, LOW/PATTERN, LOW/WIDESPREAD	• **60 day Evidence of Standards Compliance (ESC)**
LOW/LIMITED	• **60 day Evidence of Standards Compliance (ESC)**

Note: If an Immediate Threat to Health and Safety, also known as Immediate Threat to Life (ITL), is discovered during a survey, the organization immediately receives a preliminary denial of accreditation (PDA) and, within 72 hours, must either entirely eliminate that ITL or implement emergency interventions to abate the risk to patients (with a maximum of 23 days to totally eliminate the ITL). Please see the Accreditation Process Chapter within the Comprehensive Accreditation Manual for more information.

The Joint Commission
SAFER Matrix

As a result of the accreditation activity conducted, there were no Requirements for Improvement identified; therefore, the SAFER matrix is not applicable and will not appear within the report.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. *(Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your organization may need to submit a Plan Of Correction in 10 days or an ESC in 45 days.)* The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

As a result of the accreditation activity conducted, there were no Requirements for Improvement identified.

Supplemental #1
June 27, 2018
11:31 A.M.

Supplemental #2
March 29, 2018
11:59 A.M.

TN Department of Health

302

January 26, 2017

Mr. Jeffery Woods, Administrator
Trustpoint Hospital
1009 North Thompson Ln
Murfreesboro TN 37129

RE: 44-0231

Dear Mr. Woods:

The East Tennessee Regional Office conducted a complaint investigation at your facility on January 17 - 19, 2017. As a result of the investigation, no deficient practice was found.

If our office may be of assistance to you, please feel free to call (865) 594-9396.

Sincerely,

Tamra Turberville/cw

Tamra Turberville, RN, MSN
Public Health Regional Regulatory Program Manager

TT: cw

TN00038422, TN00038766, TN00038861, TN00039089, TN00040195, TN00040247

Supplemental #1
June 27, 2018
11:31 A.M.

PRINTED: 01/26/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

303

Supplemental #2
March 29, 2018
11:59 A.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440231	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTPOINT HOSPITAL	1009 NORTH THOMPSON LANE MURFREESBORO, TN 37129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS During investigation of complaint #38422, #38766, #38861, #39089, #40195, and #40247 completed 1/17/17 to 1/19/17 no deficiencies were cited related to the complaint under 42 CFR PART 483, Requirements for Hospitals.	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Supplemental #2
June 27, 2018
11:31 A.M.

PRINTED: 01/26/2017
FORM APPROVED

Division of Health Care Facilities

304

Supplemental #1
March 20, 2018
11:59 A.M.

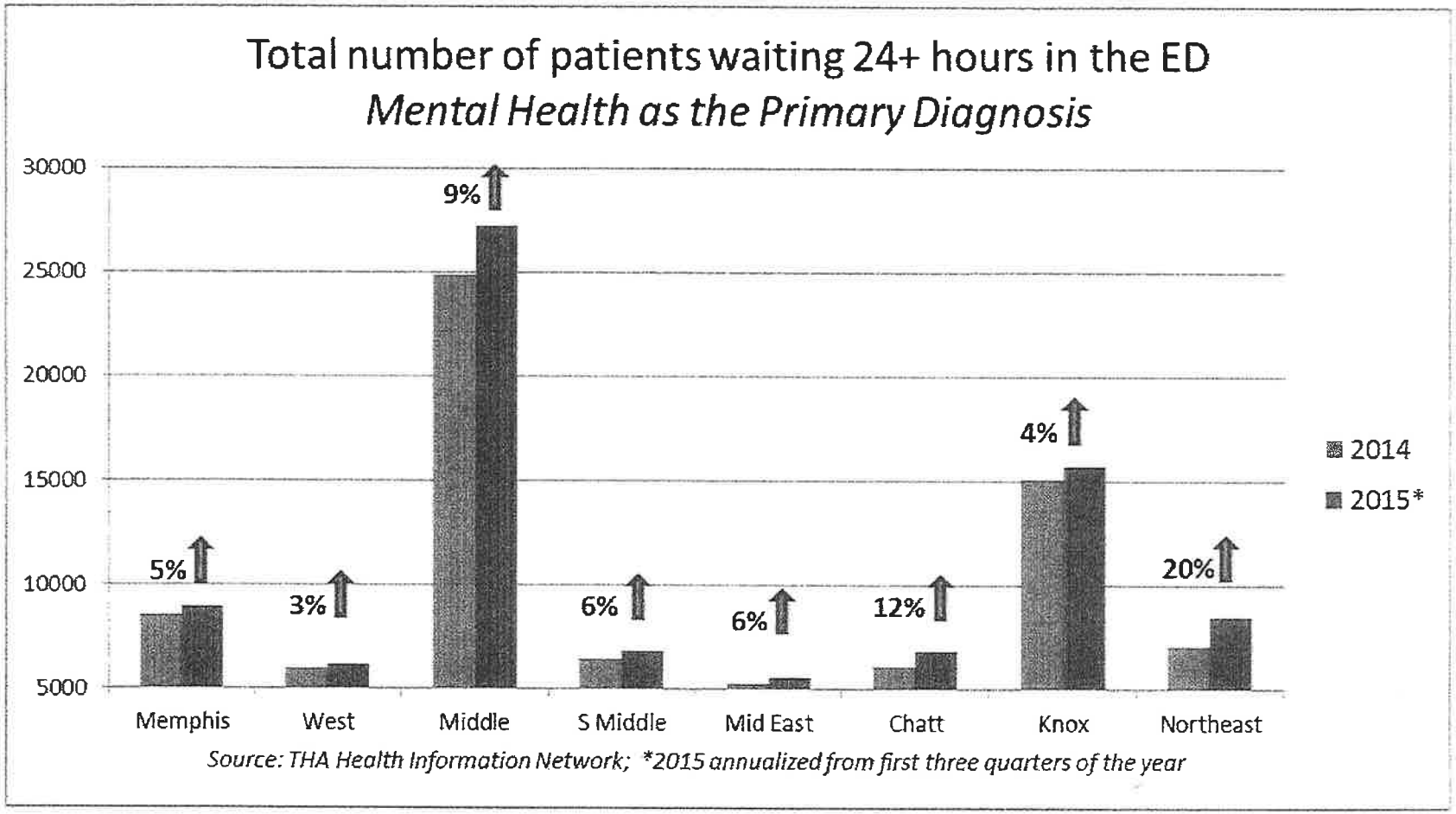
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531184	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTPOINT HOSPITAL	1009 NORTH THOMPSON LANE MURFREESBORO, TN 37129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-08-01 Initial During investigation of complaint #38422, #38766, #38861, #39089, #40195, and #40247 completed 1/17/17 to 1/19/17 no deficiencies were cited related to the complaint under Chapter 1200-08-01, Standards for Hospitals.	H 001		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

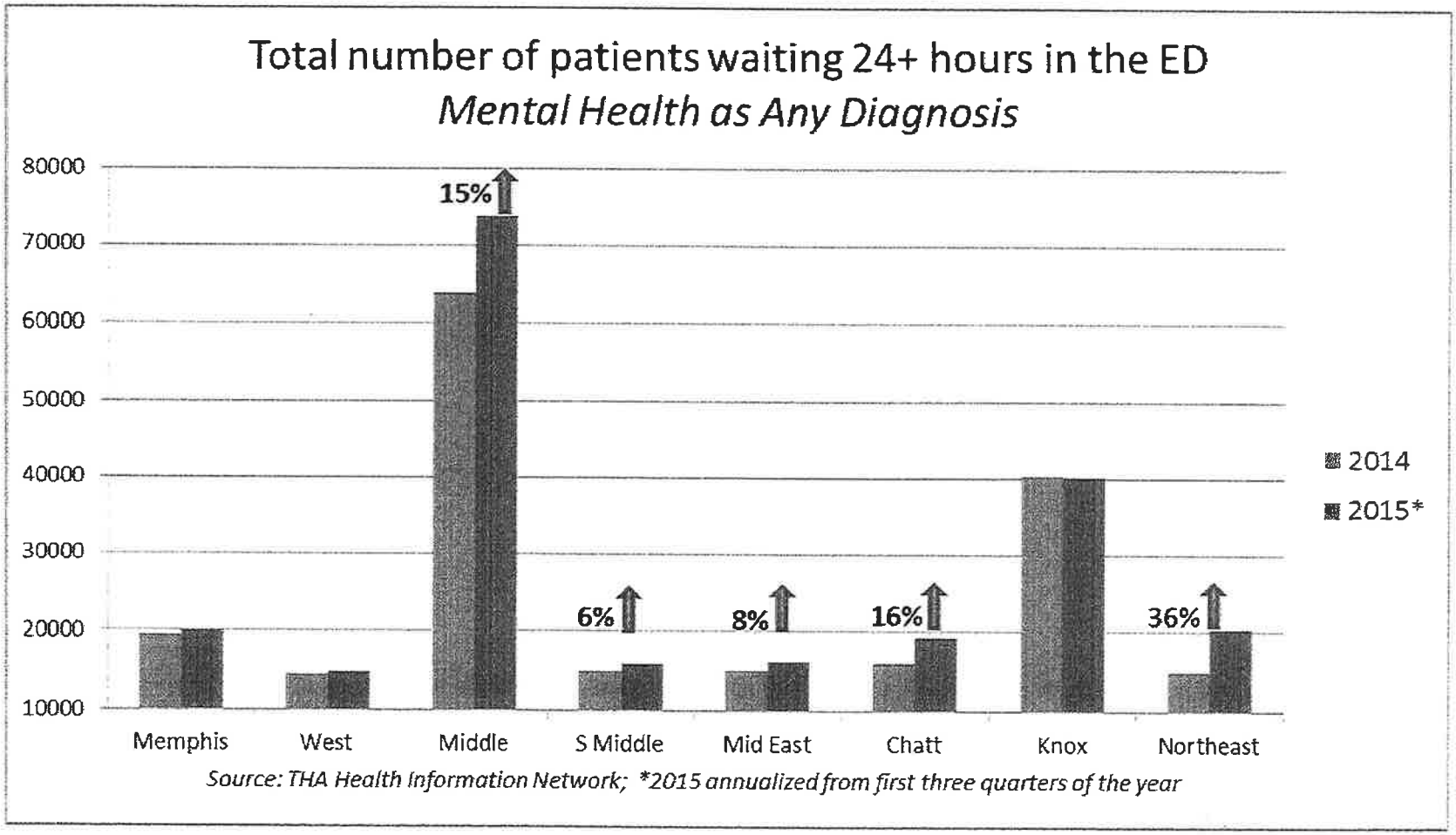
THA
TENNESSEE HOSPITAL ASSOCIATION



Supplemental TDMHSAS

Supplemental #2
June 27, 2018
11:31 A.M.

THA
TENNESSEE HOSPITAL ASSOCIATION



Supplemental #21
June 27, 2018
11:31 A.M.

Supplemental #2

Supplemental Special Warranty Deed
June 27, 2018
11:31 A.M.

Prepared by:
R. Craig Warner Warner
Glast, Phillips & Murray
2200 One Galleria Tower
13355 Noel Road., L.B. 48
Dallas, Texas 75240

Party responsible for payment of property taxes:
SEV MetroCenter IV, LLC
4011 Armory Oaks Drive
Nashville, Tennessee 37204

Tax Parcel Identification Numbers:
Map 82-1, Parcel 3; Map 71-13, Parcel 2; Map 71-13, Parcel 11;
Map 71-13, Parcel 21; Map 70-16, Parcel 2; Map 70-12, Parcel 10;
Map 70-12, Parcel 11; Map 70-16, Parcel 35; Map 70-15, Parcel 40

Davidson County DEEDWARR
Recvd: 12/21/07 15:13 16 ps
Fees:83.00 Taxes:17320.65
20071221-0146729

SPECIAL WARRANTY DEED

THE STATE OF TENNESSEE '
' KNOW ALL MEN BY THESE PRESENTS:
COUNTY OF DAVIDSON '

AMERICAN REALTY TRUST, a Georgia corporation (the "Grantor"), for and in consideration of the sum of Ten and No/100 Dollars ($10.00) cash and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, paid by SEV METROCENTER IV, LLC, a Tennessee limited liability company (the "Grantee"), whose address is 4011 Armory Oaks Drive, Nashville, Tennessee 37204, HAS GRANTED, BARGAINED, SOLD and CONVEYED, and by these presents DOES GRANT, BARGAIN, SELL and CONVEY unto Grantee that certain tract of land (the "Land") situated in Davidson County, Tennessee, and described on Exhibit "A" which is attached hereto and incorporated herein by reference for all purposes; together with all of Grantor's right, title and interest in and to the rights and appurtenances pertaining solely to such Land, including any right, title and interest of Grantor in and to the centerline of adjacent roads, streets, alleys or rights-of-way to the extent (but only to the extent) that the same relate to the Land, but specifically excluding from the interests conveyed to Grantee hereunder, Grantor's rights, title and interests in and to such rights and appurtenances to the extent they relate to other properties adjacent to, contiguous with or in close proximity to the Land (all of such Land, rights and appurtenances being hereinafter collectively referred to as the "Property").

This conveyance and warranties herein contained is made subject, however, to the matters set forth on Exhibit "B" attached hereto and incorporated herein by this reference for all purposes.

TO HAVE AND TO HOLD the Property unto Grantee, and Grantee's successors and assigns forever, and Grantor does hereby bind Grantor, and Grantor's successors and assigns, to WARRANT and FOREVER DEFEND, all and singular the Property unto Grantee and Grantee's

successors and assigns, against every person whomsoever lawfully claiming or to claim the same or any part thereof, by, through or under Grantor, but not otherwise, and subject, however, as aforesaid.

IT IS UNDERSTOOD AND AGREED THAT GRANTOR IS NOT MAKING ANY WARRANTIES OR REPRESENTATIONS OF ANY KIND OR CHARACTER, EXPRESS OR IMPLIED, WITH RESPECT TO THE PROPERTY, INCLUDING, BUT NOT LIMITED TO, NO WARRANTIES OR REPRESENTATIONS AS TO MATTERS OF TITLE (OTHER THAN GRANTOR'S SPECIAL WARRANTY OF TITLE SET FORTH HEREIN), ZONING, TAX CONSEQUENCES, PHYSICAL OR ENVIRONMENTAL CONDITION, OPERATING HISTORY OR PROJECTIONS, VALUATION, GOVERNMENTAL APPROVALS, GOVERNMENTAL REGULATIONS OR ANY OTHER MATTER OR THING RELATING TO OR AFFECTING THE PROPERTY. GRANTEE AGREES THAT WITH RESPECT TO THE PROPERTY, GRANTEE HAS NOT RELIED UPON AND WILL NOT RELY UPON, EITHER DIRECTLY OR INDIRECTLY, ANY REPRESENTATION OR WARRANTY OF GRANTOR. GRANTEE HAS CONDUCTED SUCH INSPECTIONS AND INVESTIGATIONS OF THE PROPERTY, INCLUDING, BUT NOT LIMITED TO, THE PHYSICAL AND ENVIRONMENTAL CONDITIONS THEREOF, AND IS RELYING UPON SAME, AND HEREBY ASSUMES THE RISK THAT ADVERSE MATTERS, INCLUDING, BUT NOT LIMITED TO, ADVERSE PHYSICAL AND ENVIRONMENTAL CONDITIONS, MAY NOT HAVE BEEN REVEALED BY GRANTEE'S INSPECTIONS AND INVESTIGATIONS. GRANTEE AGREES THAT IT HAS TAKEN WHATEVER ACTION AND PERFORM WHATEVER INVESTIGATIONS AND STUDIES GRANTEE HAS DEEMED NECESSARY TO SATISFY ITSELF AS TO THE CONDITION OF THE PROPERTY AND THE EXISTENCE OR NONEXISTENCE OF, OR CURATIVE ACTION TO BE TAKEN WITH RESPECT TO, ANY HAZARDOUS AND/OR TOXIC SUBSTANCES ON OR DISCHARGED TO OR FROM THE PROPERTY. GRANTEE ACKNOWLEDGES AND AGREES THAT GRANTOR IS SELLING AND CONVEYING TO GRANTEE AND GRANTEE IS ACCEPTING THE PROPERTY "AS IS, WHERE IS", WITH ALL FAULTS, AND THERE ARE NO ORAL AGREEMENTS, WARRANTIES OR REPRESENTATIONS, COLLATERAL TO OR AFFECTING THE PROPERTY BY GRANTOR OR ANY THIRD PARTY.

There having been a proration of ad valorem taxes and assessments applicable to the Property between Grantor and Grantee, by its acceptance hereof, Grantee hereby assumes and agrees to pay all ad valorem taxes and assessments assessed against the above-described property for 2008 and all subsequent years and further agree to save, defend, indemnify and hold Grantor

harmless from all such taxes and assessments; subject, however, to reproration pursuant to a separate written agreement.

EXECUTED this 19th day of December, 2007.

GRANTOR:

AMERICAN REALTY TRUST, INC., a Georgia corporation

By: _____
Steven A. Shelley, Vice President

WITNESS:

_____
Date: 12/19/07

THE STATE OF TEXAS '
'
COUNTY OF DALLAS '

This instrument was acknowledged before me on December 19, 2007 by Steven A. Shelley, Vice President of AMERICAN REALTY TRUST, INC., a Georgia corporation, on behalf of such corporation.

_____
NOTARY PUBLIC IN AND FOR
THE STATE OF TEXAS

GEORGIA E. BROOKS
Notary Public, State of Texas
My Commission Expires
December 10, 2010

Supplemental #2
June 27, 2018
11:31 A.M.

STATE OF Tennessee
COUNTY OF Davidson

The actual consideration or value for this transfer, whichever is greater, is $4,681,257.00.

SEV MetroCenter IV, LLC

By: Southeast Venture, LLC, its Manager

By: _____
Name: Stephen W. Sanders
Title: Vice-President

Subscribed and sworn to before me, this 21st day of December, 2007.

_____
NOTARY PUBLIC

CAROLE M. MAXSON
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TN

My Commission Expires:
7-19-08

Supplemental #2
June 27, 2018
11:31 A.M.

EXHIBIT "A"
TO SPECIAL WARRANTY DEED

Supplemental #1
June 27, 2018
11:31 A.M.

EXHIBIT "A"

LEGAL DESCRIPTION

THE LAND REFERRED TO HEREIN BELOW IS SITUATED IN THE COUNTY OF DAVIDSON, STATE OF TENNESSEE, AND IS DESCRIBED AS FOLLOWS:

Tract 3A

Being a parcel of land in Nashville, First Civil District, Second Councilmanic District, Davidson County, Tennessee, located on the south margin of Great Circle Road and the north margin of Interstate 65 being property conveyed to American Realty Trust, Inc., by deeds of record in Book 11503, Page 900, R.O.D.C., and being more particularly described as follows:

BEGINNING at a point at the intersection of the southerly right-of-way of Great Circle Road and the northerly right-of-way of Interstate 65;

THENCE, along said I-65 right-of-way, the following calls:

S 67° 28' 32" W, 86.10 feet to an iron pin;

S 68° 14' 00" W, 67.80 feet to an iron pin;

S 62° 54' 00" W, 69.27 feet to an iron pin;

THENCE, leaving said right-of-way along the easterly line of property conveyed to K and N Office Limited Partnership of record in Book 9728, Page 62, R.O.D.C., N 35° 12' 27" W, 228.73 feet to an iron pin in the southwesterly right-of-way of Great Circle Road;

THENCE, with said right-of-way and a curve concave to the east 377.84 feet to the point of beginning, said curve having a central angle of 77° 19' 01", a radius of 280.00 feet, a tangent of 223.99 feet, and a chord of S 73° 51' 57" E, 349.82 feet.

Containing 9,920 square feet or 0.23 acres, more or less.

Tract 4G

Being a parcel of land in Nashville, First Civil District, Second Councilmanic District, Davidson County, Tennessee, located in the southeast corner of the intersection of Great Circle Road and Vantage Way, being Lot 4G as shown on Metrocenter, Tract 4M & 4G of record in Plat Book 6200, Page 751, R.O.D.C., and being more particularly described as follows:

BEGINNING at a point in the easterly right-of-way of Great Circle Road at the termination of Vantage Way;

THENCE, leaving said right-of-way N 54° 47' 33" E, 117.00 feet to a point and the beginning of a curve to the right;

THENCE, with said curve along southerly line of property conveyed to Charles Duncan, et.ux. of record in Inst. No. 20030918138206, R.O.D.C., 165.17 feet to a point, said curve having a central angle of 17° 57' 27", a radius of 527.00 feet, a tangent of 83.27 feet, and a chord of N 63° 46' 17" E, 164.50 feet;

EXHIBIT "A"

LEGAL DESCRIPTION
(Continued)

THENCE, with said line N 72° 45' 00" E, 102.75 feet to a point in the westerly line of property conveyed to Cumberland Bend Investors, L.P. of record in Book 8800, Page 144, R.O.D.C.;

THENCE, with said westerly line S 20° 00' 00" E, 31.22 feet to a PK nail at the beginning of a curve to the right;

THENCE, continuing with said line, along said curve 194.38 feet to a point, said curve having a central angle of 55° 41' 12", a radius of 200.00 feet, a tangent of 105.64 feet, and a chord of S 67° 39' 36" E, 186.82 feet;

THENCE, along a westerly line of property conveyed to Lineberry Properties, Inc. of record in Inst. No, 2001072679269, R.O.D.C, S 39° 49' 00" E, 203.72 feet to a point at the beginning of a curve to the left;

THENCE, with said curve 93.91 feet to a point, said curve having a central angle o 43° 02' 37", a radius of 125.00 feet, a tangent of 49.29 feet, and a chord of S 61° 20' 25" E, 91.72 feet;

THENCE, with said line S 27° 15' 00" E, 250.76 feet to a point in the northerly right-of-way of Great Circle Road;

THENCE, along said right-of-way the following calls:

S 74° 20' 51" W, 107.50 feet to a concrete monument;
S 67° 28' 32" W, 223.80 feet to a concrete monument at the beginning of a curve to the right;

THENCE, with said right-of-way, along said curve 296.88 feet to a concrete monument, said curve having a central angle of 77° 19' 01", a radius of 220.00 feet, a tangent of 175.99 feet, and a chord of N 73° 51' 58" W, 274.86 feet;

THENCE, with said right-of-way N 35° 12' 27" W, 479.13 feet to the point of beginning.

Containing 321,808 square feet or 7.39 acres, more or less.

Tract 4I
Being a parcel of land in the First Civil District of Nashville, Davidson County, Tennessee, located between Lot 1, Cumberland Bend Business Park of record in Plat Book 4885, page 165, R.O.D.C., and the Cumberland River, being more particularly described as follows:

BEGINNING at an iron pin in the northerly margin of Interstate 65, said pin being N 86° 37' 37" E, 18.18 feet along said margin from the easterly margin of Great Circle Road;

THENCE, leaving said I-65 with Metro Nashville property, N 17° 58' 54" W, 270.00 feet;

THENCE, S 70° 55' 51' W, 0.69 feet to a point in the east line of 200 Cumberland Bend Real Estate, of record in Instrument No. 20011228143861, R.O.D.C.;

THENCE, with said 200 Cumberland Bend and a curve concave to the west having a central angle of 02° 01' 54",

Supplemental #2
June 27, 2018
11:31 A.M.

EXHIBIT "A"

LEGAL DESCRIPTION
(Continued)

a radius of 225.00 feet and a chord of N 20° 05' 06" W, 7.98 feet for an arc length of 7.98 feet to an iron pin;

THENCE, with a curve concave to the west having a central angle of 05° 57' 10", a radius of 3395.00 feet and a chord of N 24° 04' 36" W, 352.57 feet for an arc length of 352.73 feet to an iron pin;

THENCE, with the south line of Ambrose Printing Company, Inc., of record in Book 5847, page 133, R.O.D.C., N 62° 45' 29" E, 207.75 feet to the low water line of the Cumberland River;

THENCE, with said low water, S 25° 15' 00" E, 351.11 feet to a point;

THENCE, S 15° 00' 00" E, 350.00 feet to a point;

THENCE, S 11° 00' 00" E, 14.00 feet to a point in the north margin of I-65;

THENCE, with said margin, S 86° 36' 18" W, 197.37 feet to the Point of Beginning.

Containing 137,961 square feet or 3.17 acres, more or less.

Tract 4K

Being a parcel of land in Nashville, First Civil District, Second Councilmanic District, Davidson County, Tennessee, located north of Great Circle Road being Lot No. 2 as shown on Plat of Cumberland Bend Business Park, Section 8, of record in Plat Book 7900, page 376, and being more particularly described as follows:

BEGINNING at a point being N 27° 15' 00" W, 210.58 feet from the centerline intersection of a 25-foot common access and public utility easement and Great Circle Road;

THENCE, along the centerline of a 25-foot common access and public utility easement and a northeast line of property conveyed to Paragon Services L.L.C., of record in Instrument No. 200507070078085, R.O.D.C., N 76° 54' 00" W, 136.42 feet to a P.K. Spike;

THENCE, with a curve concave to the west and the centerline of a 30-foot common access and public utility easement, 53.44 feet to an iron pin, said curve having a central angle of 24° 29' 47", a radius of 125.00 feet, a tangent of 27.14 feet and a chord of N 18° 20' 19" E, 53.04 feet;

THENCE, with said line along said centerline, N 06° 05' 59" E, 42.31 feet to an iron pin;

THENCE, with a curve concave to the west, 73.99 feet to an iron rod, said curve having a central angle of 16° 57' 24", a radius of 250.00 feet, a tangent of 37.27 feet and a chord of N 02° 22' 43" W, 73.22 feet;

THENCE, along the centerline of a 25-foot common access and public utility easement as of record in Book 5035, page 972, R.O.D.C., and the southeastern line of property conveyed to Cumberland Investors, L.P., of record in

Supplemental #2
June 27, 2018
11:31 A.M.

EXHIBIT "A"

LEGAL DESCRIPTION
(Continued)

Instrument No. 200612180155909, R.O.D.C., N 62° 45' 29" E, 84.33 feet to a PK nail;

THENCE, with a curve concave to the south and along the centerline of a 25-foot common access and public utility easement, and the west line of property conveyed to 200 Cumberland Bend Real Estate of record in Instrument No. 20011228143861, R.O.D.C., 113.89 feet to a point, said curve having a central angle of 90° 00' 29", a radius of 72.50 feet, a tangent of 72.51 feet and a chord of S 17° 45' 14"W, 102.54 feet to a point;

THENCE, with said centerline S 27° 15' 00" E, 155.15 feet to the Point of Beginning.

Containing 12,392 square feet or 0.28 acres, more or less.

Tract 8C

Being a parcel of land in Nashville, First Civil District, Second Councilmanic District, Davidson County, Tennessee, located in the northwest corner of French Landing Drive and Venture Circle, being a portion of Lot 8C as shown on Metrocenter, Tract 8C, 8D and 8E of record in Plat Book 9700, page 921, R.O.D.C.;

BEGINNING at the point of intersection of the centerline of Venture Circle and the northeasterly right-of-way of French Landing Drive;

THENCE, with said right-of-way with and a curve concave to the south, 225.17 feet to a point, said curve having a central angle of 11° 25' 02", a radius of 1130.00 feet, a tangent of 112.96 feet, and a chord of N 55° 10' 39" W, 224.80 feet;

THENCE, leaving said right-of-way with the easterly line of property conveyed to Lagasse Family Partners, L.P., of record in Instrument No. 2002041949030, R.O.D.C., N 29° 06' 54" E, 265.65 feet to an iron pin;

THENCE, along the northerly line of said property N 66° 15' 50" W, 219.27 feet to a point;

THENCE, along the easterly line of property conveyed to Ross D. Edwards, of record in Instrument No. 200710040118474, R.O.D.C., the following calls:

N 23° 44' 10" E, 46.17 feet to a point,
S 66° 15' 50" E, 24.35 feet to a point,
N 23° 44' 10" E, 5.83 feet to a point,
S66° 15' 50" E 4.58 feet to a point,
N 23° 44' 10" E, 108.00 feet to a point,
N 66° 15' 50" W, 4.58 feet to a point,
N 23° 44' 10" E, 5.83 feet to a point;

THENCE, along the southerly line of property conveyed to Hearthwood Properties No. 4, L.L.C. of record in Instrument No. 200405270062765, R.O.D.C., and Aurora Properties L.L.C. of record in Instrument No.

EXHIBIT "A"

LEGAL DESCRIPTION
(Continued)

200607060081300, R.O.D.C. the following calls:

S 66° 15' 50" E, 379.36 feet to an iron pin,
S 34° 46' 27" E, 155.88 feet to a point in the centerline of Venture Circle;

THENCE with said centerline and a curve concave to the south 25.67 feet to a point, said cure having a central angle of 14° 42' 33", a radius of 100.00 feet, a tangent of 12.91 feet, and a chord of S 47° 52' 16" W, 25.60 feet;

THENCE, with said centerline, S 40° 31' 00" W, 385.15 feet to the Point of Beginning.

Containing 152,089 square feet or 3.49 acres, more or less.

Tract 15B
Being a parcel of land in Nashville, First Civil District, Second Councilmanic District, Davidson County, Tennessee, located on the west side of Great Circle Road being Lot 15B as shown on Metrocenter, Tracts 15A, 15B of record in Plat Book 7900, page 116, R.O.D.C., and being more particularly described as follows:

BEGINNING at an iron rod in the westerly margin of Great Circle Road at the southeast corner of herein described tract;

THENCE, leaving said margin with the northerly line of property conveyed to Self Service Mini Storage of record in Book 10511, page 276, R.O.D.C., S 72° 09' 33" W, 515.17 feet to an iron rod;

THENCE, with a curve concave to the west and the easterly line of property conveyed to Nashville Area United Way of record in Book 5345, page 229, R.O.D.C., 225.92 feet to an iron rod, said curve having a central angle of 12° 56' 39", a radius of 1000.00 feet, a tangent of 113.44 feet and a chord of N 40° 26' 33" W, 225.44 feet;

THENCE, along the southeasterly line of property conveyed to Aurora Properties, L.L.C. of record in Instrument No. 200607060081300, R.O.D.C., N 40° 53' 08" E, 557.71 feet to a point in the southwesterly right-of-way of Great Circle Road;

THENCE, along said right-of-way, S 68° 23' 52" E, 4.91 feet to a concrete monument;

THENCE, with a curve concave to the west 312.77 feet to a concrete monument, said curve having a central angle of 51° 47' 33", a radius of 346.00 feet, a tangent of 167.99 feet and a chord of S 42° 28' 28" E, 302.23 feet;

THENCE, continuing along said right-of-way S 16° 34' 43" E, 219.95 feet to the Point of Beginning.

Containing 211,725 square feet or 4.86 acres, more or less.

Supplemental #1
June 27, 2018
11:31 A.M.

EXHIBIT "A"

LEGAL DESCRIPTION
(Continued)

Tract 18A

Being a parcel of land in Nashville, First Civil District, Second Councilmanic District, Davidson County, Tennessee, located in the southwest quadrant of the intersection of Athens Way and Great Circle Road, being Lot 18A as shown on the Plat of Metrocenter, Tract 18 of record in Plat Book 8250, page 938, R.O.D.C., and being more particularly described as follows:

BEGINNING at an iron pin in the west margin of Athens Way at the southeast corner of herein described tract;

THENCE, leaving said margin, with the north line of FED VI, LLC, of record in Book 11116, page 596, R.O.D.C., N 66° 15' 50" W, 972.64 feet to an iron pin;

THENCE, with the east line of Tennessee Football, L.P., of record in Book 10933, page 809, R.O.D.C., the following calls:

With a curve concave to the west having a central angle of
02° 14' 45", a radius of 392.00 feet and a chord of
N 44° 02' 04" E, 15.36 for an arc length of 15.37 feet to a point,

N 42° 54' 41" E, 185.00 feet to a point,

With a curve concave to the east having a central angle of
60° 00' 00", a radius of 408.00 feet and a chord of
N 72° 54' 41" E, 408.00 feet for an arc length of 427.26 feet
to a monument in the south margin of Great Circle Road;

THENCE, with said margin, S 77° 05' 19" E, 519.72 feet to an iron pin;

THENCE, with a curve concave to the south having a central angle of 90° 00' 00", a radius of 50.00 feet and a chord of S 32° 05' 19" E, 70.71 feet for an arc length of 78.54 feet to an iron pin in the west margin of Athens Way;

THENCE, with said margin, S 12° 54' 41" W, 15.38 feet to an iron pin;

THENCE, with a curve concave to the west having a central angle of 10° 49' 28", a radius of 1458.00 feet and a chord of S 18° 19' 24" W, 275.04 feet for an arc length of 275.45 feet to an iron pin;

THENCE, S 23° 44' 10" W, 224.84 feet to the Point of Beginning.

Containing 422,468 square feet or 9.70 acres, more or less.

Tract 18D

Supplemental #2
June 27, 2018
11:31 A.M.

EXHIBIT "A"

LEGAL DESCRIPTION
(Continued)

Being a parcel of land in the First Civil District of Nashville, Davidson County, Tennessee located on the westerly margin of Athens Way being Lot No. 18D as shown on the Plan of Resubdivsion of Metrocenter, Tract 18C of record in Instrument No. 20051227015381S, R.O.D.C. and being more particularly described as follows:

BEGINNING at a point in the westerly margin of Athens Way at the southeast corner of herein described tract;

THENCE, leaving said margin with the north line of Lake Front Office Park, L.L.C., of record in Instrument No. 200709180111749, R.O.D.C., N64°01'02"W, 952.42 feet to a point;

THENCE, with the east line of Tennessee Football, L.P. of record in Book 10933, page 809, R.O.D.C., N19°30'00"E, 906.56 feet to a point;

THENCE, with the south line of Fed VI, LLC of record in Book 11116, page 596, R.O.D.C., S39°34'46"E, 319.57 feet to a point;

THENCE, S50°38'05"E, 144.29 feet to an iron pin;

THENCE, S66°15'50"E, 234.12 feet to an iron pin;

THENCE, with the line of Tennessee Bankers Association of record in Instrument No. 200512290156426, R.O.D.C. the following calls:

S55°10'51"W, 65.15 feet to an iron pin,
S05°54'36"E, 292.80 feet to an iron pin,
S31°37'09"W, 327.37 feet to a nail in root of 12" Hackberry,
S54°52'00"E, 316.74 feet to an iron pin in the westerly margin of Athens Way;

THENCE, with a margin and a curve concave to the west having a central angle of 01°58'14", a radius of 1867.86 feet and a chord of S38°31'03"W, 64.24 feet for an arc length of 64.24 feet to the point of beginning.

Containing 557,878 square feet or 12.81 Acres, more or less.

Tract 30

Being a parcel of land in Nashville, First Civil District, Second Councilmanic District, Davidson County, Tennessee, located on the west margin of Great Circle Road being Lot No. 30 as shown on the Resubdivision of Lots 30 & 30A, Metrocenter, Section 2 of record in Plat Book 7900, page 331, R.O.D.C., and being more particularly described as follows:

BEGINNING at an iron pin in the westerly right-of-way of Great Circle Road being the northeast corner of herein described tract;

EXHIBIT "A"

LEGAL DESCRIPTION
(Continued)

THENCE, along said right-of-way, S 11° 19' 00" E, 294.04 feet to a concrete monument;

THENCE, with said right-of-way and a curve concave to the east 244.71 feet to an iron pin, said curve having a central angle of 26° 53' 37", a radius of 521.34 feet, a tangent of 124.65 feet, and a chord of S 24° 45' 48" E, 242.47 feet;

THENCE, leaving said right-of-way with the northerly line of property conveyed to Triple Five, LLC, of record in Instrument No. 200212060150690, R.O.D.C., the following calls:

S 51° 47' 21" W, 60.00 feet to an iron pin;
S 77° 07' 00" W, 489.75 feet to a point in an easterly line of property conveyed to Metropolitan Government Rhodes Municipal Park of record in Book 5588, page 393, R.O.D.C.;

THENCE, with said Park property the following calls:

N 06° 43' 50" E, 422.28 feet to a point;
N 11° 19' 00" W, 159.15 feet to a point;

THENCE, with the southerly line of property conveyed to Ebon-Falcon L.L.C., of record in Instr. No. 200709070107478, R.O.D.C., N 77° 07' 00" E, 356.00 feet to the Point of Beginning.

Containing 229,412 square feet or 5.27 acres, more or less.

Being part of the same property conveyed to American Realty Trust, Inc., a Georgia corporation by Special Warranty Deed from SunTrust Banks, Inc., a Georgia corporation of record in Book 11503, page 900, Register's Office for Davidson County, Tennessee.

Supplemental #21
June 27, 2018
11:31 A.M.

EXHIBIT "B"
TO SPECIAL WARRANTY DEED

1. Taxes for the year of 2008 and subsequent years.

2. Restrictive Covenant in favor of Arby's Inc. of record in Book 9382, page 56 said Register's Office.

3. Restrictive Covenant in favor of Taco Bell Corp., of record in Book 9420, page 176 said Register's Office.

4. Terms, provisions, covenants, conditions, restrictions, easements, charges, assessments and liens provided in the Covenants, Conditions and Restrictions of record in Book 7487, page 952 and as amended in Book 10602, Page 499, and as affected by Waiver in Instrument No. 20060531-0063833, said Register's Office.

5. Terms, conditions, easements, rights and liens in favor of Mat-Nel Company, as set forth in the Master Deed of record in Book 5028, page 333, as amended in Book 5035, page 972, said Register's Office.

6. Subject to all matters shown on the Plan of record in Plat Book 4675, page 48, Register's Office for Davidson County, Tennessee.

7. Easement for Ingress and Egress of record in Book 4927, page 511, said Register's Office, granted to serve Lot No. 1 on the plan of MetroCenter of record in Book 4675, page 48, and Lot No. 2A on the plan of Metrocenter of record in Book 5060, page 85, said Register's Office, as shown on survey of Barge, Waggoner, Sumner & Cannon dated May 25, 1999, Wendell H. Talley, Sr., TRLS No. 785, File No. 11469-85.

8. Divided Tank with 42" RCP as shown on said survey.

9. Restrictive Covenants of record in Book 4784, page 659, as amended by Amendment to Protective Covenants and Waiver of Repurchase Right for Metrocenter Tracts, of record in Book 11503, page 607, said Register's Office.

10. Subject to all matters shown on the Plan of record in Plat Book 6200, page 751, Register's Office for Davidson County, Tennessee.

11. Subject to all matters shown on the Plan of record in Plat Book 4660, page 181, Register's Office for Davidson County, Tennessee.

12. Cheatham Dam Flowage Easement of record in Book 2281, page 631, as amended in Book 2290, page 256, said Register's Office.

13. Title to that portion of the premises lying between the high and low water marks of the Cumberland River.

14. 15 foot Right-of-Way Easement granted to Colonial Pipeline Company of record in Book 5039, page 193, as amended in Book 5232, page 252, said Register's Office.

15. Permanent Levee Access Easement of record in Instrument No. 20001101-0108591, said Register's Office.

16. Subject to all matters shown on the Plan of record in Plat Book 7900, page 376, Register's Office for Davidson County, Tennessee.

17. 30 foot common access and public utility easement for Cumberland Bend as shown on the plan attached as Exhibit "A" to instrument of record in Book 5035, page 972, said Register's Office, and specifically shown on page 975, and as shown on the plat of record in Book 7900, page 376, Register's Office for Davidson County, as shown on said survey.

18. Subject to rights of others in and to the common areas/elements, consisting of the common access areas shown on the Plan of record in Book 7900, page 376, said Register's Office.

19. Subject to all matters shown on the Plan of record in Plat Book 9700, page 921, Register's Office for Davidson County, Tennessee.

20. Terms, conditions, easements, rights and liens as set forth in The Master Deed of record in Book 5026, page 783, as amended in Book 5035, page 967, said Register's Office, in favor of MetroCenter Properties.

21. 15 foot Electrical Easement of record in Book 7900, page 116, said Register's Office.

22. Common Access and Utility Easement (Venture Circle, a private road) of record in Book 7900, page 116, said Register's Office.

23. Subject to all matters shown on the Plan of record in Plat Book 7900, page 116, Register's Office for Davidson County, Tennessee.

24. Nashville Electric Service Pad Easement of record in Book 4945, page 593, said Register's Office.

25. Easement Agreement by and between American Realty Trust, Inc. and Hearthwood Properties No. 4, LLC, a Tennessee limited liability company, of record in Instrument No. 20050721-0085321, said Register's Office.

26. Waiver of Special Covenants and Restrictions of record in Instrument No. 20060531-0063833, said Register's Office.

27. Subject to all matters shown on the Plan of record in Plat Book 8250, page 938, Register's Office for Davidson County, Tennessee.

28. Council Bill No. 73-608 which provides for the dedication of permanent easements for the operation and maintenance of the pumping station and outlet works, levees, lakes and canals as needed for flood control and will also provide for reasonable public access for recreational use of the lakes, canals and levee areas, as shown on survey of Barge, Waggoner, Sumner and Cannon dated May 25, 1999, by Wendell H. Talley, Sr., TRLS No. 785, File No. 11469-85, and as amended by Council Bill 86-1346 to abandon the recreation easement and amend other aspects of the original bill, and as further amended by council Bill No. 092-494 in which Metropolitan Government assumes responsibility for operation and maintenance of the pumping station.

29. Terms, provisions and conditions of any and all permits relating to the conservation easement shown on the plat of record in Book 8250, page 938, said Register's Office, including U.S. Army Corps of Engineers file 97002700 and Tennessee Department of Environment and Conservation, Division of Water Pollution Control, Aquatic Resource Alteration Permit #97-248.

30. Subject to all matters shown on the Plan of Resubdivision of MetroCenter, Tract 18C, of record in Instrument No. 20051227-0153815, Register's Office for Davidson County, Tennessee.

31. Subject to all matters shown on the Plan of record in Plat Book 7900, page 331, Register's Office for Davidson County, Tennessee.

32. Subject to rights of others in and to the common areas and/or elements.

33. Underground and PAD Mounted Transformer Easement of record in Book 5055, page 81, Register's Office of Davidson County, Tennessee.

34. 50 Foot common access and public utility easement of record in Plat Book 4885, page 165, Register's Office of Davidson County, Tennessee.

35. Subject to matters shown on surveys of William C. Cockrill, TN RLS No. 1401, of Barge, Waggoner, Sumner & Cannon, Inc., dated December 20, 2007.

Supplemental #1

Supplemental Earnest Money
June 27, 2018
11:31 A.M.

OLD REPUBLIC TITLE

201 Fourth Avenue North, Suite 150, Nashville, TN 37219-2005 | T: 615.244.2101

April 4, 2017

Waller Lansden Dortch & Davis
Attn: Ms. Jeanette Ramer
Nashville City Center
511 Union Street, Suite 2700
Nashville, TN 37219-1760

Re: 300 Great Circle Road

Dear Ms. Ramer:

This is to confirm the receipt of $10,000.00 from Acadia Healthcare Company, Inc. and $65,000.00 from Acadia Healthcare Company, Inc. This is earnest money related to the Purchase and Sale Agreement between SEV Metrocenter IV, LLC and Acadia Healthcare Company, Inc. The money has been placed in a non-interest bearing account set up for this matter. The file number is 171519.

If you need any additional information I can be reached at yhall@oldrepublictitle.com. Thank you for your business.

Sincerely,

Yvonne Hall

Yvonne Hall
Accountant

Supplemental #1
Supp 12/21/2018 Notice
11:31 A.M.

December 21, 2017

VIA E-MAIL

Acadia Healthcare Company, Inc.
6100 Tower Circle, Suite 1000
Franklin, TN 37067
Attention: Keith Thompson, Esq. (Keith.Thompson@acadiahealthcare.com)

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219
Attention: J. Steven Kirkham, Esq. (Steve.Kirkham@wallerlaw.com)

Re: Notification of Satisfaction of Conditions and Requirements

Gentlemen:

Reference is made to that certain Purchase and Sale Agreement dated March 29, 2017, as amended by that certain First Amendment to Purchase and Sale Agreement dated July 27, 2017, and as further amended by that certain Second Amendment to Purchase and Sale Agreement dated December 5, 2017 (as amended, the "**PSA**"), by and between SEV Metrocenter IV, LLC, a Tennessee limited liability company (the "**Seller**"), and Acadia Healthcare Company, Inc., a Delaware corporation (the "**Buyer**"). Capitalized terms used but not otherwise defined herein shall have the meanings assigned to such terms in the PSA.

Pursuant to Section 4.5.7 of the PSA, Seller has previously obtained and provided to Buyer a Hydrologic Determination from The Division of Water Resources of the Tennessee Department of Environment and Conservation which permits the relocation of the current drainage feature located on the Property. Accordingly, Seller has satisfied all of the conditions and requirements contained in Section 4.5.7 of the PSA.

In addition, pursuant to Section 4.5.6 of the PSA, Seller has obtained all necessary governmental approvals in order to change the zoning of the Property from "IWD – Industrial Warehousing/Distribution" to "MUG – Mixed-Use General", as defined in the Code of the Metropolitan Government of Nashville and Davidson County, Tennessee (the "**Rezoning**"). The Rezoning will be official and become effective as of January 2, 2018 (the "**Rezoning Date**"). As of the Rezoning Date, Seller shall have satisfied all of the conditions and requirements contained in Section 4.5.6 of the PSA.

Based on the satisfaction of the conditions and requirements of Sections 4.5.6 of the PSA, the Approvals Period shall commence on the Rezoning Date and shall end on August 30, 2018 unless Buyer exercises an Approvals Extension in accordance with Section 3.4 of the PSA. This notice is being provided for the convenience of Buyer and does not modify any terms of the

PSA. Upon Buyer's execution and acknowledgement of this notice, Buyer shall conclusively be deemed to agree to the subject matter and dates set forth herein.

SEV METROCENTER IV, LLC

By: Southeast Venture LLC, Manager

By: _____
Name: Cameron W. Sorenson
Title: Member

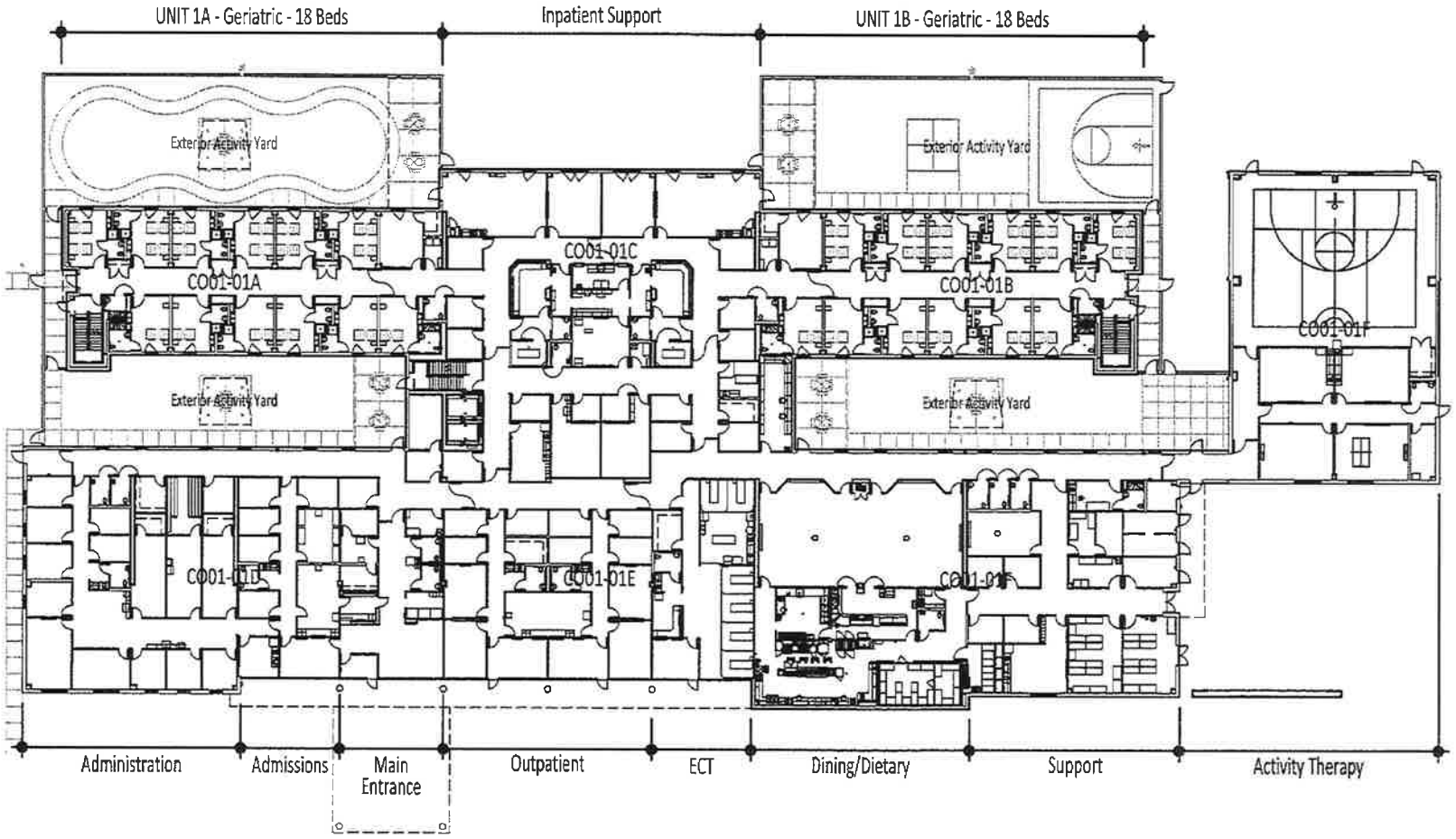
Acknowledged and agreed to by:

ACADIA HEALTHCARE
COMPANY, INC.

By: _____
Name: Christopher Howard
Title: EVP & General Counsel

cc: John Seehorn (jseehorn@bassberry.com)

24018202.2



FIRST FLOOR BUILDING AREA = 52,600 SF

COMPOSITE FIRST FLOOR PLAN C001-01

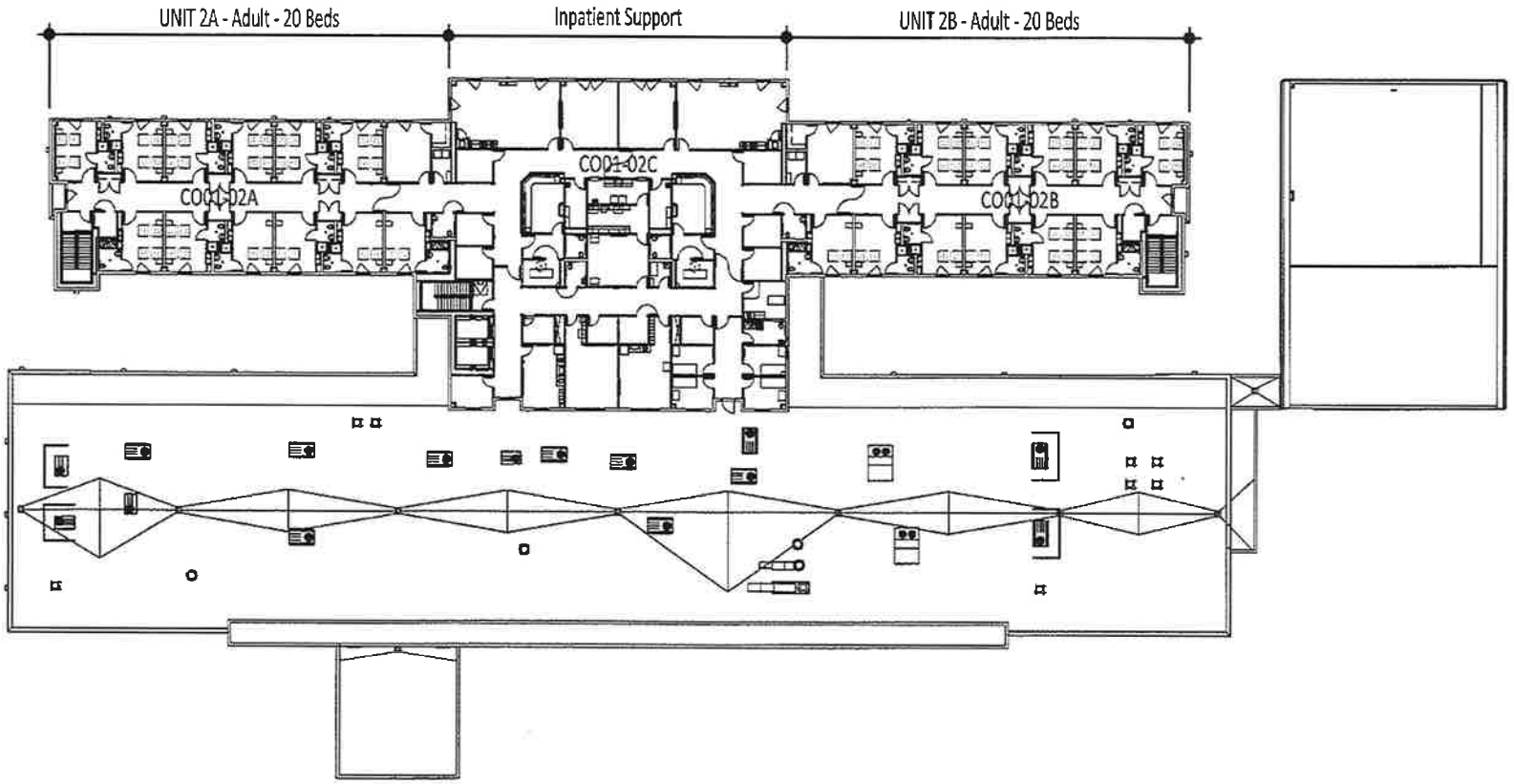
NORTH

GRAPHIC SCALE

0' 25' 50' 100'

NEW BEHAVIORAL HEALTH HOSPITAL
Acadia Healthcare Company - Nashville, Tennessee
September 13, 2017

Supplemental #2
Supplemental for 2018 prints
11:31 A.M.



SECOND FLOOR BUILDING AREA = 20,000 SF

COMPOSITE SECOND FLOOR PLAN C001-02

NORTH

GRAPHIC SCALE

0' 25' 50' 100'

NEW BEHAVIORAL HEALTH HOSPITAL
Acadia Healthcare Company - Nashville, Tennessee
September 13, 2017

Supplemental #2
June 27, 2018
11:31 A.M.

The Applicant's goal of providing these appropriate and needed services is consistent with the State Health Plan, and this project will improve the health of Tennesseans.

2. **Access:** People in Tennessee should have access to health care and the conditions to achieve optimal health.

Response: The Applicant will provide psychiatric services currently needed by all adult and geriatric citizens in the service area, thereby increasing the availability of such services.

3. **Economic Efficiencies:** Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging value and economic efficiencies.

Response: The development of services by the Applicant's owners has always been the result of attempts to meet the needs of the patients they serve. There is an unmet need for adult and geriatric care in the service area. Therefore, the approval of this application will enhance the development of more psychiatric services for residents in the proposed service area.

4. **Quality of care:** People in Tennessee should have confidence that the quality of care is continually monitored, and standards are adhered to by providers.

Response: Tennessee is fortunate to have an excellent licensing division of the Department of Mental Health and Substance Abuse Services (the "Department"). The Department also provides standards for and monitoring of licensed health care providers. This Applicant will be licensed by the Department of Mental Health and Substance Abuse Services, will be certified by Medicare and Medicaid (TennCare), and will be accredited by the JCAHO.

5. **Workforce:** The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

Response: The Applicant is committed to providing its staff both safe working conditions and continuing education.

Definitions

Psychiatric inpatients services: Shall mean the provision of psychiatric and substance services to persons with a mental illness, serious emotional disturbance (children), or substance use diagnosis in a hospital setting, as defined in TCA 33-1-0101(14); residential treatment services and crisis stabilization unit services are not included in this definition.

Service Area: The county or counties represented on an application as the reasonable area in which a psychiatric inpatient facility intends to provide services and/or in which the majority of

its service recipients reside.

Medical Detox: The intensive 24-hour treatment for service recipients to systematically reduce or eliminate the amount of a toxic agent in the body until the signs and symptoms of withdrawal are resolved. Medical detoxification treatment requires medical and professional nursing services to manage withdrawal signs and symptoms.

This definition applies to general hospital beds, licensed by the Tennessee Department of Health (TDH), in a unit that provides psychiatric treatment services and/or substance use treatment services. These services are provided both while the patient is detoxed and after detox has occurred.

This definition applies to mental health hospital beds, licensed by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), in a unit that provides psychiatric treatment services and/or substance use treatment services. These services are provided both while the patient is detoxed and after detox has occurred.

Standards and Criteria

1. **Determination of Need:** The population-based estimate of the total need for psychiatric inpatient services is a guideline of 30 beds per 100,000 general population, using population estimates prepared by the TDH and applying the applicable data in the Joint Annual Reports (JAR). These estimates represent gross bed need and shall be adjusted by subtracting the existing applicable staffed beds including certified beds in outstanding CONs operating in the area as counted by the TDH in the JAR. For adult programs, the age group of 18-64 years shall be used in calculating the estimated total number of beds needed; additionally, if an applicant proposed a geriatric psychiatric unit, the age range 65+ shall be used. For child inpatients, the age group of 12 and under, and if the program is for adolescents, the age group of 13-17 shall be used. The HSDA may take into consideration data provided by the applicant justifying the need for additional beds that would exceed the guideline of 30 beds per 100,000 general population. Special consideration may be given to applicants seeking to serve child, adolescent, and geriatric inpatients. Applicants may demonstrate limited access to services for these specific age groups that supports exceeding the guideline of 30 beds per 100,000 general population. An applicant seeking to exceed this guideline shall utilize TDH and TDMHSAS data to justify this projected need and support the request by addressing the factors listed under the criteria "Additional Factors."

   Rationale: Many communities in Tennessee have unique needs for inpatient psychiatric beds. The above formula functions as a "base criteria" that allows applicants to provide evidence supporting a need for a higher number of beds in the proposed service area. The HSDA may take into account all evidence provided and approve applications that request beds that exceed the 30 beds per 100,000 guideline when needed. An analysis of admissions and discharges by age performed by the HSDA suggests there may be limited access for inpatients under the age of 18 and inpatients aged 65 and over. However, the applicable JAR form does not provide occupancy rates by age category. Health Planning believes developing determination of need

formulas specific to each age category is not possible at this time due to these limitations in available data. The current need formula is to be utilized as a guideline allowing applicants the opportunity to apply to serve the unique needs of the intended service area.

Response: The Standard and Criteria of 30 beds per 100,000 formula was utilized. The Applicant believes the current formula understates the need for inpatient psychiatric services, as explained in the application and replicated here, in part.

It is proposed to construct/establish a new psychiatric inpatient hospital for the care of adult and geriatric patients. The total inpatient psychiatry hospital beds requested in this application is 76, comprised as follows:

Adult Psychiatry Unit 1	20 beds
Adult Psychiatry Unit 2	20 beds
Geriatric Psychiatry Unit 1	18 beds
Geriatric Psychiatry Unit 2	18 beds
Total Inpatient	76 beds.

Proposed Adult Psychiatry Service: The adult psychiatry program will comprise two treatment units with a combined 40 beds providing inpatient mental health and substance abuse services for adults age 18 to 64. The first treatment unit will be 20 beds, specializing in the care of adult psychiatric patients with *serious* mental illness as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (e.g., mood disorders, co-occurring disorders) (American Psychiatric Association, 2013). The second treatment unit will be 20 beds, specializing in the care of adult psychiatric patients with *severe* mental illness as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (e.g., psychosis, thought disorders, developmental disabilities, and imminent risk of danger to self or others). *Id.*

Proposed Geriatric Psychiatry Service: The geriatric psychiatry program will comprise two treatment units with a combined 36 beds providing inpatient mental health and substance abuse services for adult patients age 65 and over with a primary acute psychiatric diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association, 2013). The first treatment unit will be 18 beds, specializing in the care of geriatric patients with serious psychiatric, neuro-cognitive, and behavioral disturbances. The second treatment unit will be 18 beds, specializing in the care of geriatric patients with severe mental illness associated with disturbance of mood, co-occurring disorders, and adjustment. It is intended that the existing patients occupying the 24 geriatric inpatient psychiatry beds located at Saint Thomas West Hospital will move to this new hospital. Saint Thomas West Hospital has not specified their intended use for those vacated beds at this time but has stated that it will decrease its licensed bed capacity by 24 beds once the beds in this application are licensed.

2. **Additional Factors:** An applicant shall address the following factors:

a. The willingness of the applicant to accept emergency involuntary and non-emergency indefinite admissions;

b. The extent to which the applicant serves or proposed to serve the TennCare population and the indigent population;

c. The number of beds designated as "specialty" beds (including units established to treat patients with specific diagnoses);

d. The ability of the applicant to provide a continuum of care such as outpatient, intensive outpatient treatment (IOP), partial hospitalization, or refer to providers that do;

e. Psychiatric units for patients with intellectual disabilities;

f. Free standing psychiatric facility transfer agreements with medical inpatient facilities;

g. The willingness of the provider to provide inpatient psychiatric services to all populations (including those requiring hospitalization on an involuntary basis, individuals with co-occurring substance use disorders, and patients with comorbid medical conditions); and

h. The applicant shall detail how the treatment program and staffing patterns align with the treatment needs of the patients in accordance with the expected length of stay of the patient population.

i. Special consideration shall be given to an inpatient provider that has been specially contracted by the TDMHSAS to provide services to uninsured patients in a region that would have previously been served by a state operated mental health hospital that has closed.

j. Special consideration shall be given to a service area that does not have a crisis stabilization unit available as an alternative to inpatient psychiatric care.

Response: All four units will accept voluntary and involuntary admissions pursuant to Tennessee Code Annotated §33-6-404.

All programs and services will accept and care for patients with commercial, managed care, Medicare, Tri-Care and TennCare forms of payment. All service lines will accept charity and unfunded patients as a function of our mission to serve the broader community.

As a guiding principle, Cumberland Behavioral Health will provide care in the least restrictive environment for all patients. Care is planned and provided with the dignity and safety of the patient at the center of the treatment experience. Services will be exclusively provided to adult and geriatric patients. The facility design allows patients to have access off-unit to engage in social, recreational, and therapeutic groups and activities. Patients will dine in a spacious cafeteria unless their clinical condition requires tray service to their unit. Staffing is designed to ensure the constant presence, at all times, of registered nurses and behavioral health technicians. The treatment team is supplemented with Activity Therapists, Music Therapists, Licensed Social Workers,

Psychologists, Registered Dieticians, Occupational and Physical Therapists, Nurse Practitioners, Drug and Alcohol Counselors, and such other professionals as may be needed to meet the unique needs of the patient population. This proposed staffing will provide patients with a clinically diverse and enriching program to promote recovery and return to normal living. Acadia and Saint Thomas Health have a strong network of academic affiliations for the recruitment, training, and hiring of clinical and non-clinical personnel. Partnering with local universities, colleges, trade schools, and traditional non-academic recruitment strategies will support the human resources needed to fully staff the hospital. All clinical staff will be recruited consistent with the Hospital's Human Resource practices, which include: advertisement in local and regional newspapers, recruitment web sites, work fairs, universities, colleges, and direct applications from prospective employees. See staffing matrices included in Section B.H of the application.

By separating the adult and geriatric patient populations by major diagnostic classifications and severity of illness, the Applicant will be better able to provide care that is tailored to the individual needs of patients in an environment that is safe, efficient, and highly reliable.

Researchers Hankin, Bronstone, and Koran (2011) found that psychiatric patients with psychosis and other forms of thought disorder present a high risk for acts of violence against themselves and others. The nature of the patient's illness, together with the potential triggers resulting in risk for harm, support the need for distinct treatment units specific to the needs of varied populations (Hankin et al., 2011). Further, this hospital will support the long-term population growth in Davidson, Cheatham, and Robertson Counties, and the needs of other surrounding counties that may rely on the Applicant for inpatient psychiatric.

All treatment units are designed with semi-private rooms, which still allows for single occupancy as needed for the individualized care requirement of patients.

This project will involve new construction with a cost estimated at just under $24 million.

This project will significantly improve much needed access to state of the art facilities and treatment of psychiatric patients, reduce the overwhelming burden on an already taxed care delivery system, and reduce the enormous pressure faced by emergency departments holding psychiatric patients in need of inpatient care.

We will have a transfer agreement with Saint Thomas West and Saint Thomas Midtown. We hope to have either transfer agreements or working arrangements with all other acute facilities in our service area.

In addition,

1. The current system for access to inpatient psychiatric care continues to be in crisis with patients boarding for extensive periods of time in emergency departments (hours, days, and weeks);

2. Patients have a right of choice in their care provider, and should have access to state of the art facilities and treatment to meet their complex mental health care needs;

3. Existing services are inadequate to meet the immediate and future needs of the community: not enough beds, geographic reach, diversity of care options and providers, rapidly growing population; and

4. TDMHSAS statistics show more than 27,000 patients waiting in emergency departments for more than 24 hours with mental health as primary diagnosis due to lack of beds and capacity to serve – an increase of 9% over prior year (THA and TDMHSAS, 2015 most recent data). This phenomenon is not getting better, only worse, with no substantive change in access to care opportunities for many years.

Finally, according to "The State of Mental Health in America 2018," an in-depth report by Mental Health America (formerly the National Mental Health Association), several disturbing facts were uncovered regarding the mental health ranking of the State of Tennessee, as follows:

1. Tennessee's overall ranking (indicating both a higher prevalence of mental illness and lower rates of access to care) is 46th out of all states plus the District of Columbia;
2. 39th in prevalence of mental illness;
3. 44th in adult psychiatric care;
4. 44th in mental health workforce availability;
5. 44th in incidents of depression;
6. 50th in adults with any mental illness who are uninsured;
7. 5th in adult alcohol dependence; and
8. 11th in adult use of marijuana.

While this application focuses on geriatric and adult populations, Tennessee also ranks poorly in psychiatric care for youth, as follows:

1. The 7th highest rate of prevalence of mental illness;
2. 2nd in alcohol dependence;
3. last (51st) in access to care youth;
4. 49th in youth Major Depressive Episodes ("MDE"); and
5. 51st in care for youth that did not receive treatment for MDE.

The licensure of this new seventy-six (76) bed hospital will result in a net increase of only fifty-two (52) beds, since Saint Thomas West will at that point voluntarily surrender the twenty-four (24) beds currently providing geriatric psychiatric care.

There are five existing facilities in Davidson County that provide inpatient psychiatric care. One of these facilities, at Saint Thomas West, will voluntarily surrender its beds once the beds requested in this application are approved and licensed. Due to the need for inpatient psychiatric care, there should be minimal impact on existing providers.

All of Cheatham and Robertson Counties are medically underserved areas, according to Health Resources and Services Administration, as are many census tracts in Davidson County. The

addition of more psychiatric beds in the service area will add more health care services and staff. See **Attachment B.Need.D.2** for a list of the MUA tracts in the three counties.

Please see **Attachment B.Need.D.1.a** (9 pages) for more Quick Facts about the primary service area.

3. **Incidence and Prevalence:** The applicant shall provide information on the rate of incidence and prevalence of mental illness and substance use within the proposed service area in comparison to the statewide rate. Data from the TDMHSAS or the Substance Abuse and Mental Health Services Administration (SAMHSA) shall be utilized to determine the rate. This comparison may be used by the HSDA staff in review of the application as verification of need in the proposed service area.

   Rational: The rate of incidence and prevalence of mental illness in the service area may indicate a need for a higher number of psychiatric inpatient beds in the designated area.

Response: See No. 2 above.

4. **Planning Horizon:** The applicant shall predict the need for psychiatric inpatient beds for the proposed first two years of operation.

   Rational: The Division believes that projecting need two years into the future is more likely to accurately reflect the coming trends and less likely to overstate potential future need.

Response: The Applicant anticipates a utilization rate (converted to patients from patient days) of 28.6 and 53.5 patients in years 1 and 2 of operation. Further, the application states as follows:

Service Area Counties	**Projected Utilization-County Residents**	**# and % of total patients**
County #1	Davidson	20.7 and 72.4%
	Cheatham	1.3 and 4.5%
	Robertson	2.3 and 8.1%
	Other Middle Tennessee Counties	4.3 and 15.0%
Total		28.6 and 100%

Note: The facility's projected primary service area is Davidson, Cheatham, and Robertson Counties, Tennessee.

The Applicant projects that approximately 85% of the patients will probably originate from the primary service area, with the remaining 15% originating from other counties in Middle Tennessee. The assumption was also made that of the three counties in the primary service area, patient origination would reflect the same percentage as did the target population of each county to the whole. For example, 85.1% of the total primary service area target population resided in Davidson County, and the assumption was made that 85.1% of the total patients from the three

STATE OF TENNESSEE

STATE HEALTH PLAN

CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

Psychiatric Inpatient Services

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to provide psychiatric inpatient services. Rationale statements are provided for standards to explain the Division of Health Planning's (Division) underlying reasoning and are meant to assist stakeholders in responding to these Standards and to assist the HSDA in its assessment of certificate of need (CON) applications. Existing providers of psychiatric inpatient services are not affected by these Standards and Criteria unless they take an action that requires a new CON for such services.

These Standards and Criteria are effective immediately upon approval and adoption by the Governor. However, applications to provide psychiatric inpatient services that are deemed complete by the HSDA prior to the approval and adoption of these Standards and Criteria shall be considered under the Guidelines for Growth, 2000 Edition.

The Certificate of Need Standards and Criteria serve to uphold the Five Principles for Achieving Better Health set forth by the State Health Plan. Utilizing the Five Principles for Achieving Better Health during the development of the CON Standards and Criteria ensures the protection and promotion of the health of the people of Tennessee. The State Health Plan's Five Principles for Achieving Better Health are as follows:

1. **Healthy Lives:** The purpose of the State Health Plan is to improve the health of people in Tennessee.

Response: The Applicant will provide inpatient psychiatric care to adult and geriatric patients in a service area in need of such services. Due to the increasing need for inpatient psychiatric care (previously reported in this application), there continues to be a need for psychiatric hospital beds.

counties of the primary service area would originate from Davidson County, 5.5% from Cheatham County and 9.4% from Robertson County. With those assumptions in mind, the Projected Utilization (2nd chart above) for Year 1 was completed using the following projections:

28.6 patients x 85% x 85.1% = 20.7 patients from Davidson County,
28.6 patients x 85% x 5.5% = 1.3 patients from Cheatham County,
28.6 patients x 85% x 9.4% = 2.3 patients from Robertson County, and
the resulting 4.3 patients from surrounding counties.

5. **Establishment of Service Area:** The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The proposal's sensitivity and responsiveness to the special needs of the service area shall be considered, including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, other medically underserved populations, and those who need services involuntarily. The applicant may also include information on patient origination and geography and transportation lines that may inform the determination of need for additional services in the region.

   Applicants should be aware of the Bureau of TennCare's access requirement table, found under "Access to Behavioral Health Services" on pages 93-94 at http://www.tn.gov/assets/entities/tenncare/attachment/operationalporotcol.pdf.

   Rationale: In many cases it is likely that a proposed psychiatric facility's service area could draw more significantly from only a portion of a county. When available, the Division would encourage the use of sub-county level data that are available to the general public (including utilization, demographic, etc.) to better inform the HSDA in making its decisions. Because psychiatric patients often select a facility based on the proximity of caregivers and family members, as well as the proximity of the facility, factors other than travel time may be considered by the HSDA. Additionally, geography and transportation lines may limit access to services and necessitate the availability of additional psychiatric inpatient beds in specific service areas.

Response: The proposed primary service area includes Davidson, Cheatham and Robertson Counties. All of Cheatham and Robertson Counties are medically underserved areas, according to Health Resources and Services Administration, as are many census tracts in Davidson County. The addition of more psychiatric beds in the service area will add more health care services and staff. See **Attachment B.Need.D.2** for a list of the MUA tracts in the three counties.

6. **Composition of Services:** Inpatient hospital services that provide only substance use services shall be considered separately from psychiatric services in a CON application; inpatient hospital services that address co-occurring substance use/mental health needs shall be considered collectively with psychiatric services. Providers shall also take into account concerns of special populations (including, e.g., supervision of adolescents, specialized geriatric, and patients with comorbid medical conditions).

The composition of population served, mix of populations, and charity care are often affected by status of insurance, TennCare, Medicare, or TriCare; additionally, some facilities are eligible for Disproportionate Share Hospital payments based on the amount of charity care provided, while others are not. Such considerations may also result in a prescribed length of stay.

Rationale: Because patients with psychiatric conditions often experience co-morbid conditions, it is important that providers be capable of addressing such patients' potential medical needs. The accessibility of psychiatric services to various populations and for appropriate lengths of stay are important considerations for the HSD when reviewing psychiatric inpatient services applications.

Response: This Applicant will be licensed by the Department of Mental Health and Substance Abuse Services, will be certified by Medicare and Medicaid (TennCare), and will be accredited by the JCAHO. All programs and services will accept and care for patients with commercial, managed care, Medicare, Tri-Care and TennCare forms of payment. All service lines will accept charity and unfunded patients as a function of our mission to serve the broader community.

7. **Patient Age Categorization:** Patients should generally be categorized as children (0-12), adolescents (13-17), adults (18-64), or geriatrics (65+). While an adult inpatient psychiatric service can appropriately serve adults of any age, an applicant shall indicate if they plan to only serve a portion of the adult population so that the determination of need may be based on that age-limited population. Applicants shall be clear regarding the age range they intend to serve; given the small number of hospitals who serve younger children (12 and under), special consideration shall be given to applicants serving this age group. Applicants shall specify how patient care will be specialized in order to appropriately care for the chosen patient category.

   Rational: Based on stakeholder input, the Division has categorized the patient population into children, adolescents, adults, and geriatric. Each age category may require unique care.

Response: Proposed Adult Psychiatry Service: The adult psychiatry program will comprise two treatment units with a combined 40 beds providing inpatient mental health and substance abuse services for adults age 18 to 64. The first treatment unit will be 20 beds, specializing in the care of adult psychiatric patients with *serious* mental illness as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (e.g., mood disorders, co-occurring disorders) (American Psychiatric Association, 2013). The second treatment unit will be 20 beds, specializing in the care of adult psychiatric patients with *severe* mental illness as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (e.g., psychosis, thought disorders, developmental disabilities, and imminent risk of danger to self or others). *Id.*

Proposed Geriatric Psychiatry Service: The geriatric psychiatry program will comprise two treatment units with a combined 36 beds providing inpatient mental health and substance abuse services for adult patients age 65 and over with a primary acute psychiatric diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association, 2013). The first treatment unit will be 18 beds, specializing in the care of geriatric patients with serious psychiatric, neuro-cognitive, and behavioral disturbances. The second

treatment unit will be 18 beds, specializing in the care of geriatric patients with severe mental illness associated with disturbance of mood, co-occurring disorders, and adjustment. It is intended that the existing patients occupying the 24 geriatric inpatient psychiatry beds located at Saint Thomas West Hospital will move to this new hospital. Saint Thomas West Hospital has not specified their intended use for those vacated beds at this time.

8. **Services to High-Need Populations:** Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are involuntarily committed, uninsured, or low-income.

Response: This Applicant will be licensed by the Department of Mental Health and Substance Abuse Services, will be certified by Medicare and Medicaid (TennCare), and will be accredited by the JCAHO. All programs and services will accept and care for patients with commercial, managed care, Medicare, Tri-Care and TennCare forms of payment. All service lines will accept charity and unfunded patients as a function of our mission to serve the broader community.

9. **Relationship to Existing Applicable Plans; Underserved Area and Populations:** The proposal's relationships to underserved geographic areas and underserved population groups shall also be a significant consideration. The impact of the proposal on similar services in the community supported by state appropriations shall be assessed and considered; the applicant's proposal as to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, shall also be assessed and considered. The degree of projected financial participation in the Medicare and TennCare programs shall be considered.

   Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the trends ion occupancy and utilization of those services. This discussion shall also include how the applicant's services may differ from existing services (e.g., specialized treatment of an age-limited group, acceptance of involuntary admissions, and differentiation by payor mix). Accessibility to specific special need groups shall also be discussed in the application.

   Rationale: Based on stakeholder input, a number of factors, including occupancy, shall be considered in the context of general utilization trends. Additionally, several factors may be necessary to consider when determining occupancy including staffed beds verses licensed beds, the target patient population, and the operation of specialty units.

Response: All of Cheatham and Robertson Counties are medically underserved areas, according to Health Resources and Services Administration, as are many census tracts in Davidson County. The addition of more psychiatric beds in the service area will add more health care services and staff. See **Attachment B.Need.D.2** for a list of the MUA tracts in the three counties.

10. **Expansion of Established Facility:** Applicants seeking to add beds to an existing facility shall provide documentation detailing the sustainability of the existing facility. This documentation shall include financials, and utilization rates. A facility seeking approval for expansion should have maintained an occupancy rate for all licensed beds of at least 80 percent

for the previous year. The HSDA may take into consideration evidence provided by the applicant supporting the need for the expansion or addition of services without the applicant meeting the 80 percent threshold. Additionally, the applicant shall provide evidence that the existing facility was built and operates, in terms of plans, service area, and populations served, in accordance with the original project proposal.

Rationale: Based on stakeholder input, the implementation of an 80 percent threshold for the approval may serve as an indicator of economic feasibility for the expansion of the facility. The 80 percent occupancy requirement may limit an applicant's ability to add specialty services that require separation from other unites. Examples include geriatric psychiatry, services for patients with co-occurring mental health needs and substance use disorders. Additionally, the majority of the programs in the state are currently operating under this threshold. The communities these programs serve may have needs that require an expansion of services. An applicant may provide evidence of the economic feasibility of expansion despite not operating at or above 80 percent of capacity.

Response: Not applicable.

11. **Licensure and Quality Considerations:** Any existing applicant for this CON service category shall be in compliance with the appropriate rules of the TDH and/or the TDMHSAS. The applicant shall also demonstrate its accreditation status with the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or other applicable accrediting agency. Such compliance shall provide assurances that applicants are making appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems, and children who need quiet space). Applicants shall also make appropriate accommodations so that patients are separated by gender in regard to sleeping as well as bathing arrangements. Additionally, the applicant shall indicate how it would provide culturally competent services in the service area (e.g., for veterans, the Hispanic population, and LBGT population).

Response: This hospital will be fully accredited by the Joint Commission, certified by the Centers for Medicare and Medicaid Services, and licensed by the Tennessee Department of Mental Health and Substance Abuse Services. The hospital will provide its clinical services following established, evidence-based best practices. The hospital will meet the same high standards for quality, safety, and reliability as found in both Acadia and Saint Thomas Health facilities.

12. **Institution for Mental Disease Classification:** It shall also be taken into consideration whether the facility is or will be classified as an Institution for Mental Disease (IMD). The criteria and formula involve not just the total number of beds, but the average daily census (ADC) of the inpatient psychiatric beds in relation to the ADC of the facility. When a facility is classified as an IMD, the cost of patient care for Bureau of TennCare enrollees aged 21-64 will be reimbursed using 100 percent state funds, with no matching federal funds provided; consequently, this potential impact shall be addressed in any CON application for inpatient psychiatric beds.

Response: Cumberland Behavioral Health will meet the Federal definition for an Institution for Mental Disease (IMD).

13. **Continuum of Care:** Free Standing inpatient psychiatric facilities typically provide only basic acute medical care following admission. This practice has been reinforced by Tenn. Code Ann. § 33-4-104, which requires treatment at a hospital or by a physician for a physical disorder prior to admission if the disorder requires immediate medical care and the admitting facility cannot appropriately provide the medical care. It is essential, whether prior to admission or during admission, that a process be in place to provide for or to allow referral for appropriate and adequate medical care. However, it is not effective, appropriate, or efficient to provide the complete array of medical services in an inpatient psychiatric setting.

Response: Acadia Healthcare operates several adult, geriatric, and chemical dependency inpatient and outpatient programs in Tennessee. The Acadia Healthcare Tennessee facilities include Crestwyn Behavioral Health Hospital (Memphis), Delta Medical Center (Memphis), TrustPoint Hospital (Murfreesboro), Erlanger Behavioral Health Hospital (newly licensed June 2018 - Chattanooga), Villages Behavioral Health (non-acute adolescent residential program - Louisville), and Mirror Lake Recover Center (non-acute adult residential program - Burns). Additionally, Acadia Healthcare operates hundreds of psychiatric hospitals and treatment programs across the United States, United Kingdom, and Puerto Rico, making it a leading provider of inpatient and outpatient behavioral health services.

14. **Data Usage:** The TDH and the TDMHSAS data on the current supply and utilization of licensed and CON-approved psychiatric inpatient beds shall be the data sources employed hereunder, unless otherwise noted. The TDMHJSAS and the TDH Division of Health Licensure and Regulation have data on the current number of licensed beds. The applicable TDH JAR provides data on the number of beds in operation. Applicants should utilize data from both sources in order to provide an accurate bed inventory.

    Rationale: Using these sources for data is the only way to ensure consistency across the evaluation of all applications. Data provided by the TDH and the TDMHSAS shall be relied upon as the primary sources of data for CON psychiatric inpatient services applications. Each data source has specific caveats. Requiring the use of both licensed beds and operating beds will provide a more comprehensive bed inventory analysis.

Response: The Applicant relied on TDH and TDMHSAS data for this application.

15 **Adequate Staffing:** An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, asses competencies of, supervise, and retain he appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed Service Area. Each applicant shall outline planned staffing patterns including the number and type of physicians. Additionally, the applicant shall address what kinds of shift are intended to be utilized (e.g., 8 hour, 12 hour, or Baylor plan). Each unit is required to be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times. This staffing level is the minimum necessary to provide safe care. The applicant shall state how the proposed staffing plan will lead to quality care of the patient population served by the project.

However, when considering applications for expansions of existing facilities, the HSDA may determine whether the existing facility's staff would continue without significant change and thus would be sufficient to meet this standard without a demonstration of efforts to recruit new staff.

Response: Acadia and Saint Thomas Health have a strong network of academic affiliations for the recruitment, training, and hiring of clinical and non-clinical personnel. Partnering with local universities, colleges, trade schools, and traditional non-academic recruitment strategies will support the human resources needed to fully staff the hospital. All clinical staff will be recruited consistent with the Hospital's Human Resource practices, which include: advertisement in local and regional newspapers, recruitment web sites, work fairs, universities, colleges, and direct applications from prospective employees.

Proposed staffing and salary/wage data are an average of cost by category of employee. The following staffing matrices reflect proposed staffing based on bed allocations requested in this Certificate of Need proposal.

Adult Psychiatry:

ADULT PSYCHIATRY: 2 UNITS at 20 BEDS EACH					Salary/Wage
	CENSUS	1-10	11-15	16-20	
	DIRECTOR	0.5	0.5	0.5	$96,000/YR
	NRS MGR	1	1	1	$70,000/YR
DAYS/EVENINGS	RN/LPN	1	2	2	Avg $25-32/hr
	MHA	1	1	2	Avg $14-16/hr
	CLERICAL	1	1	1	Avg $14-16/hr
	SOCIAL WORK	1	1.5	2	Avg $22-30/hr
NIGHTS	RN/LPN	1	2	2	Avg $25-32/hr
	MHA	1	1	1.5	Avg $14-16/hr
HOUSE SUPERVISOR (RN)					$75,000/YR

At least one RN must be scheduled each shift.
NRS MGR = Nurse Manager

MHA = Mental Health Associate

Geriatric Psychiatry:

GERIATRIC PSYCHIATRY: 2 UNITS at 18 BEDS EACH					Salary/Wage
	CENSUS	1-6	7-12	13-18	
	DIRECTOR	0.5	0.5	0.5	$96,000/YR
	NRS MGR	1	1	1	$70,000/YR
DAYS/EVENINGS	RN/LPN	1	2	3	Avg $25-32/hr
	MHA	2	2	3	Avg $14-16/hr
	CLERICAL	1	1	1	Avg $14-16/hr
	Social Work	1	1.5	2	Avg $22-30/hr
NIGHTS	RN/LPN	2	2	2	Avg $25-32/hr
	MHA	1	1	2	Avg $14-16/hr
HOUSE SUPERVISOR (RN)					$75,000/YR

At least one RN must be scheduled each shift.
NRS MGR = Nurse Manager
MHA = Mental Health Associate

16. **Community Linkage Plan:** The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/services and working agreements with other related community services assuring continuity of care (e.g., agreements between freestanding psychiatric facilities and acute care hospitals, linkages with providers of outpatient, intensive outpatient, and/or partial hospitalization services). If they are provided, letters from providers (e.g., physicians, mobile crisis teams, and/or managed care organizations) in support of an application shall detail specific instances of unmet need for psychiatric inpatient services. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

    Rationale: The Division recognized that participation in community linkage plans is an important element in the provision of quality psychiatric inpatient services; therefore, it is important for applicants to demonstrate such connections with other community providers. The 2014 update to tie State Health Plan moved from a primary emphasis of health care to an emphasis on "health protection and promotion." The development of primary prevention initiatives for the community advances the mission of the State Health Plan.

Response: We will have a transfer agreement with Saint Thomas West and Saint Thomas Midtown. We hope to have either transfer agreements or working arrangements with all other

acute facilities in our service area.

17. **Access:** The applicant must demonstrate an ability and willingness to serve equally all of the patients related to the application of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed service area.

Response: All programs and services will accept and care for patients with commercial, managed care, Medicare, Tri-Care and TennCare forms of payment. All service lines will accept charity and unfunded patients as a function of our mission to serve the broader community.

18. **Quality Control and Monitoring:** The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. An applicant that owns or administers other psychiatric facilities shall provide information on their surveys and their quality improvement programs at those facilities, whether they are located in Tennessee or not.

    Rationale: This section supports the State Health Plan's Fourth Principle for Achieving Better Health regarding quality of care.

Response: This hospital will be fully accredited by the Joint Commission, certified by the Centers for Medicare and Medicaid Services, and licensed by the Tennessee Department of Mental Health and Substance Abuse Services. The hospital will provide its clinical services following established, evidence-based best practices. The hospital will meet the same high standards for quality, safety, and reliability as found in both Acadia and Saint Thomas Health facilities.

Cumberland Behavioral Health will engage a robust data collection, monitoring, reporting, and process improvement structure to identify and promote best practices, improve patient outcomes, and ensure safe and efficient care delivery that is compliant with state and federal regulatory requirements and Joint Commission standards. Among data collection and reporting activities, Cumberland Behavioral Health will collect and report the following types of quality data:

- CMS Core Measures
- HCAPHPS and HBIPS
- Hospital Inpatient Quality Reporting (CMS)
- Sentinel or Serious Safety Events
- Hospital Acquired Infections
- Antimicrobial Stewardship
- Internal Reporting of Improvement Initiatives and Outcomes

19. **Data Requirements:** Applicants shall agree to provide the TDH, the TDMHSAS, and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services at the applicant's facility and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

Response: The Applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

Cumberland Behavioral Health will engage a robust data collection, monitoring, reporting, and process improvement structure to identify and promote best practices, improve patient outcomes, and ensure safe and efficient care delivery that is compliant with state and federal regulatory requirements and Joint Commission standards. Among data collection and reporting activities, Cumberland Behavioral Health will collect and report the following types of quality data:

- CMS Core Measures
- HCAPHPS and HBIPS
- Hospital Inpatient Quality Reporting (CMS)
- Sentinel or Serious Safety Events
- Hospital Acquired Infections
- Antimicrobial Stewardship
- Internal Reporting of Improvement Initiatives and Outcomes

The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	05/08/2018 - 05/11/2018	Requirements for Improvement	Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

The Joint Commission
What's Next - Follow-up Activity

Program: Hospital

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Evidence of Standard Compliance (within 60 calendar days)
EC.02.01.01	5	Low / Limited	§482.41 (a)	A-0701	✓
EC.02.05.01	9	Low / Limited	§482.41 (a)	A-0701	✓
IC.02.01.01	2	Low / Limited			✓
IC.02.02.01	2	Moderate / Pattern	§482.42	A-0747	✓
			§482.51	A-0940	✓
	4	Low / Widespread	§482.42	A-0747	✓
			§482.42 (a)	A-0748	✓
LD.04.01.05	4	Moderate / Limited			✓
LD.04.03.09	5	Low / Limited	§482.12 (e)	A-0083	✓
	6	Low / Limited	§482.12 (e)(1)	A-0084	✓
LS.02.01.10	14	Low / Limited	§482.41 (b)(1)(i)	A-0710	✓
LS.02.01.20	10	Low / Limited	§482.41 (b)(1)(i)	A-0710	✓
	14	Low / Pattern	§482.41 (b)(1)(i)	A-0710	✓
LS.02.01.35	14	Low / Limited	§482.41 (b)(1)(i)	A-0710	✓
	4	Low / Limited	§482.41 (b)(1)(i)	A-0710	✓

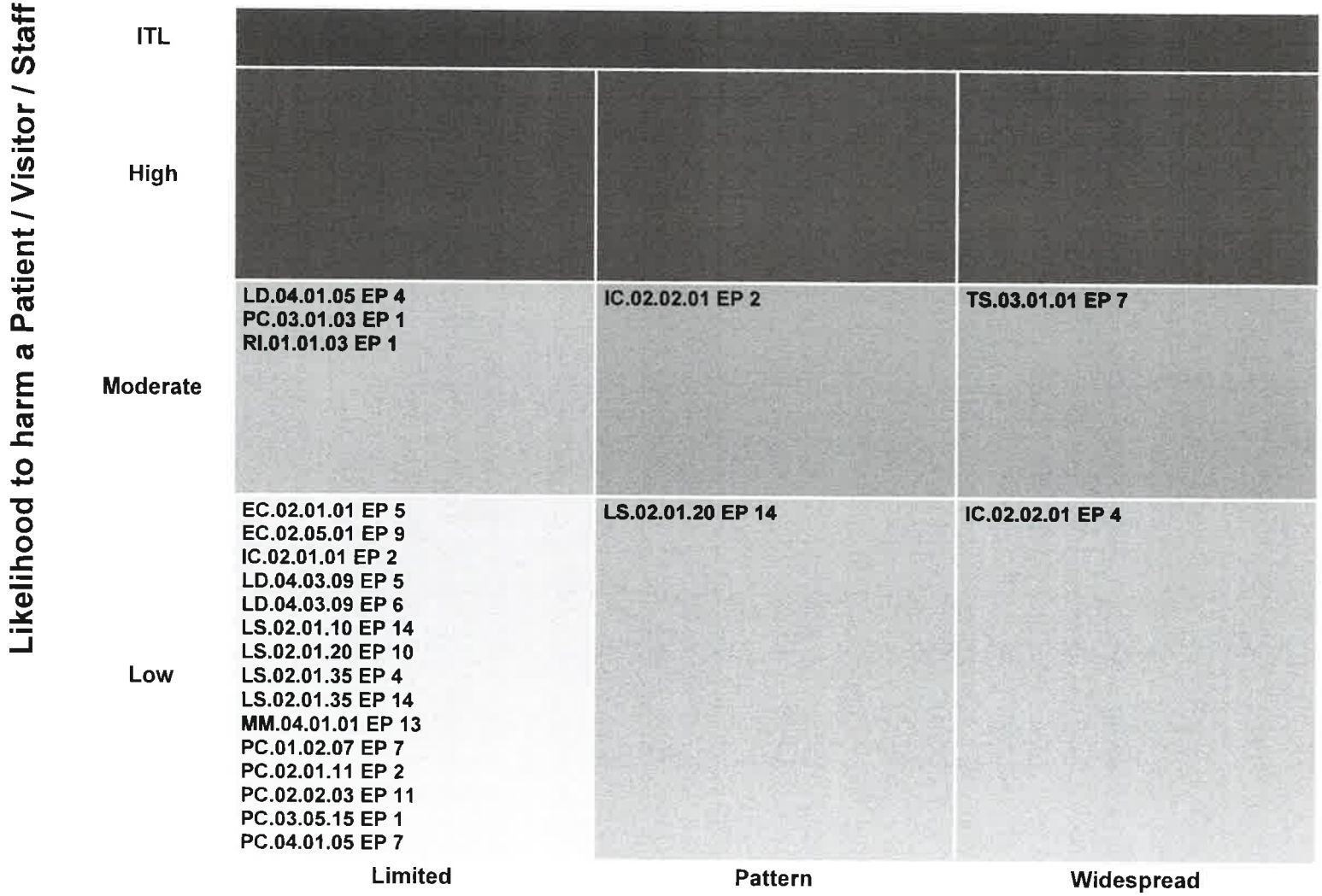
Supplemental #1
June 27, 2018
11:31 A.M.

The Joint Commission

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Evidence of Standard Compliance (within 60 calendar days)
MM.04.01.01	13	Low / Limited	§482.23 (c)(3)	A-0406	✓
PC.01.02.07	7	Low / Limited			✓
PC.02.01.11	2	Low / Limited			✓
PC.02.02.03	11	Low / Limited			✓
PC.03.01.03	1	Moderate / Limited			✓
PC.03.05.15	1	Low / Limited	§482.13 (e)(16)(iv)	A-0187	✓
PC.04.01.05	7	Low / Limited	§482.43 (c)(5)	A-0820	✓
RI.01.01.03	1	Moderate / Limited			✓
TS.03.01.01	7	Moderate / Widespread			✓

Supplemental #X 1
June 27, 2018
11:31 A.M.

The Joint Commission
SAFER™ Matrix
Program: Hospital



Supplemental #2
June 27, 2018
11:31 A.M.

The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Hospital

CoP(s)	Tag	CoP Score	Corresponds to:
§482.13	A-0115	Standard	
§482.13(e)(16)(iv)	A-0187	Standard	HAP/PC.03.05.15/EP1
§482.23	A-0385	Standard	
§482.23(c)(3)	A-0406	Standard	HAP/MM.04.01.01/EP13
§482.41	A-0700	Standard	
§482.41(a)	A-0701	Standard	HAP/EC.02.01.01/EP5 HAP/EC.02.05.01/EP9
§482.41(b)(1)(i)	A-0710	Standard	HAP/LS.02.01.10/EP14 HAP/LS.02.01.20/EP10 HAP/LS.02.01.20/EP14 HAP/LS.02.01.35/EP4 HAP/LS.02.01.35/EP14
§482.42	A-0747	Standard	HAP/IC.02.02.01/EP2 HAP/IC.02.02.01/EP4
§482.42(a)	A-0748	Standard	HAP/IC.02.02.01/EP4
§482.43	A-0799	Standard	
§482.43(c)(5)	A-0820	Standard	HAP/PC.04.01.05/EP7
§482.51	A-0940	Standard	HAP/IC.02.02.01/EP2
§482.12	A-0043	Standard	
§482.12(e)	A-0083	Standard	HAP/LD.04.03.09/EP5
§482.12(e)(1)	A-0084	Standard	HAP/LD.04.03.09/EP6

Supplemental #2
June 27, 2018
11:31 A.M.

The Joint Commission
Requirements for Improvement

Program: Hospital

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.01.01	5	Low Limited	The hospital maintains all grounds and equipment.	1). Observed in Building Tour at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . The trash compactor located on the back dock was found to be operated without the safety key.	§482.41(a)	Standard
EC.02.05.01	9	Low Limited	The hospital labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.	1). Observed in Building Tour at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . In 1 of 5 electrical panel checks, In 1 of 5 electrical panel checks, It was noted that the electrical panel labeled 15LBC16 had breakers #1 and #7 in the on position but were labeled as spare.	§482.41(a)	Standard
IC.02.01.01	2	Low Limited	The hospital uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. (See also EC.02.02.01, EP 4) Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During tracer activities, a single-use bottle of hydrogen peroxide was found in a wound kit basket. The bottle of hydrogen peroxide bottle seal was broken, when asked about single-patient-use versus multiple-patient-use, the staff member reported that it was multiple-patient-use. The organization's policy states that these small bottles are for single-patient-use only. The hospital leadership who observed this exchange, confirmed this policy. The bottle of hydrogen peroxide was immediately discarded.		
IC.02.02.01	2	Moderate Pattern	The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During tracer activities (Radiation Oncology), a review of the post-procedural transporting of the rhinolaryngoscope revealed incorrect handling (via	§482.42	Standard

Supplemental #4
June 27, 2018
11:31 A.M.

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes. Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).	towel). After coaching with staff and department leadership, the corrected process (a rigid container labeled bio-hazardous) was implemented by the end of the survey day.		
				2). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During tracer activities (Speech Therapy), a review of the HLD process revealed the OPA Metricide Plus control strips were not being maintained in an area where the temperature was being monitored. Department leadership plans to correct this observation soon.	§482.42	Standard
				3). Observed in Document Review at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During tracer activity in Sterile Processing Department, it was observed that a control biological indicator was resulted as negative for one day in May 2018 and no follow-up was done. This was documented on paper. The department was undergoing several transitions (new biological indicators and transitioning to electronic documenting) but still documenting on paper and resulted in a misdocumentation according to the manager of Sterile Processing Department.	§482.51	Standard
				4). Observed in Building Tour at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During tracer activity of the Soiled Utility Room shared by the 2nd floor ICUs, it was observed that multiple hinged instruments were dirty, dry, and in an open container. These instruments were removed by an SPD staff and taken to the decontamination area for reprocessing. Of note, according to the director of the ICUs, they use disposable	§482.51	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				instruments so she did not know where these instruments came from.		
IC.02.02.01	4	Low Widespread	The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During tracer activities, a review of the intubation tackle box sitting atop the emergency cart, revealed the laryngoscope handle unprotected. The handle was found laying in the box without a proper wrapper to prevent recontamination. A discussion with a Respiratory staff member revealed that this was the standard practice throughout the organization. This observation led to immediate corrective action, the handles were cleaned and placed into a zip-lock bag for protection to prevent recontamination (during this survey).	§482.42	Standard
				2). Observed in Tracer Visit at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . Magill Forceps, in respiratory box were not protected to prevent recontamination. (e.g. lying on bottom of a drawer)	§482.42(a)	Standard
LD.04.01.05	4	Moderate Limited	Staff are held accountable for their responsibilities.	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . In the Dialysis Unit, the patient's dialysis order stated 2.0 potassium bath and 2.5 calcium. The patient was at the end of the dialysis treatment and had received a bath of 1.0 potassium and 2.5 calcium. This was confirmed by the charge nurse and the unit manager. The bath was immediately changed to the correct bath.		
LD.04.03.09	5	Low Limited	Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it.	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During contract review (Tennessee Perfusion Associates, Inc.), no specific quality/performance indicators (metrics) could be found listed in the contract. This contract expires 6/30/2019.	§482.12(e)	Standard
LD.04.03.09	6	Low Limited	Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations.	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During contract review (Cardiovascular Anesthesiologist, P.C.), quality indicators (metrics) were listed for 2015 and 2016, however, no quality	§482.12(e)(1)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				indicators (metrics) were listed for years 2017 and 2018. This contract is effective through year 2019. Additionally, no evidence of reporting of said metrics could be found.		
LS.02.01.10	14	Low Limited	The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material. Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text, refer to NFPA 101-2012: 8.3.5)	1). Observed in Building Tour at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . The 2 hour rated fire wall near the mail room had a 1 inch open penetration with I.T. cabling passing through it.This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission	§482.41(b)(1)(i)	Standard
LS.02.01.20	10	Low Limited	New stairs serving three or more stories and existing stairs serving five or more stories have signs on each floor landing in the stairwell that identify the story, the stairwell, the top and bottom, and the direction to and story of exit discharge. Floor level information is also presented in tactile lettering. The signs are placed five feet above the floor landing in a position that is easily visible when the door is open or closed. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.2.2.5.4)	1). Observed in Building Tour at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . In 1 of 21 Stairways, The stairwell at the end of 3C did not have the required signage inside the stairwell. This was an 8 story building.This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission	§482.41(b)(1)(i)	Standard
LS.02.01.20	14	Low Pattern	Exits, exit accesses, and exit discharges (means of egress) are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text, refer to NFPA 101-2012: 18/19.2.5.1; 7.1.10.1; 7.5.1.1) Note 1: Wheeled equipment (such as equipment and carts currently in use, equipment used for patient lift and transport, and medical emergency equipment not in use) that maintains at least five feet of clear and unobstructed corridor width is allowed, provided there is a fire plan and training program addressing its relocation in a fire or similar emergency. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (4)) Note 2: Where the corridor width is at least eight feet and the smoke compartment is fully protected by an electrically supervised smoke detection system or is	1). Observed in Building Tour at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . While conducting a survey of the 4B wing it was noted that there were 13 pieces of equipment such as work stations on wheels, and vital sign machines that were being charged and stored in the corridor.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: ILSM not applicable(EP-15)	§482.41(b)(1)(i)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			in direct supervision of facility staff, furniture that is securely attached is allowed provided it does not reduce the corridor width to less than six feet, is only on one side of the corridor, does not exceed 50 square feet, is in groupings spaced at least 10 feet apart, and does not restrict access to building service and fire protection equipment. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (5))			
LS.02.01.35	4	Low Limited	Piping for approved automatic sprinkler systems is not used to support any other item. (For full text, refer to NFPA 25-2011: 5.2.2.2)	1). Observed in Building Tour at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . In 1 of 10 above ceiling checks, While conducting a survey above the ceiling near the entrance to 7A it was noted that there was a 3/4 inch electrical conduit being supported by the approved automatic sprinkler system.This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission	§482.41(b)(1)(i)	Standard
LS.02.01.35	14	Low Limited	The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012: 18/19.3.5.	1). Observed in Building Tour at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . There was a 2 inch diameter hole in the ceiling membrane of the gift shop. This was a fully sprinkled room with a smoke detector near the penetration. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission	§482.41(b)(1)(i)	Standard
MM.04.01.01	13	Low Limited	The hospital implements its policies for medication orders.	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During tracer activities (Renal/Diabetes Unit), a medical record review revealed a prn "breakthrough" intravenous morphine sulfate ordered for pain, missing the severity descriptor (mild, moderate, or severe) for which it was to be administered. The medication was being administered for pain with a severity scale number documented. After review of a couple policies (Medication Process: Ordering, Policy Stat ID: 3086805, effective 07/2017 and PRN Therapeutic Duplication, PolicyStat ID: 1496834,	§482.23(c)(3)	Standard

Supplemental #2
June 27, 2018
11:31 A.M.

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				effective 06/2015), it could not be determined that the descriptor for which pain medication should be administered (in the LIP order), was a required element. Unit leadership witnessed this observation.		
				2). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During tracer activities (Pulmonary Unit), a medical record review revealed a oxycodone pill ordered for pain, missing the severity descriptor (mild, moderate, or severe) for which it was to be administered. The medication was being administered for pain with a severity scale number documented. After review of a couple policies (Medication Process: Ordering, Policy Stat ID: 3086805, effective 07/2017 and PRN Therapeutic Duplication, PolicyStat ID: 1496834, effective 06/2015), it could not be determined that the descriptor for which pain medication should be administered (in the LIP order), was a required element. Unit leadership witnessed this observation.	§482.23(c)(3)	Standard
PC.01.02.07	7	Low Limited	The hospital reassesses and responds to the patient's pain through the following: - Evaluation and documentation of response(s) to pain intervention(s) (See also RC.01.01.01, EP 7) - Progress toward pain management goals including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control) - Side effects of treatment - Risk factors for adverse events caused by the treatment	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During tracer activities (Medical-Surgical unit), a medical record review, revealed only 1 out of 4 pain reassessments documented the severity of pain intervention. Unit leadership was present during these observations.		
PC.02.01.11	2	Low Limited	Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During tracer activities (Cancer Center), a emergency cart log book was found missing a check on 4-MAY-2018. It was reported by leadership that the center was in operation on that day.		
PC.02.02.03	11	Low Limited	The hospital stores food and nutrition products, including those brought in by patients or their	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN)		

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			families, using proper sanitation, temperature, light, moisture, ventilation, and security.	site . During tracer activities (Cancer Center), the patient nutrition refrigerator temperature log was missing a temperature check on 4-MAY-2018. Leadership reported that the center was in operation that day.		
PC.03.01.03	1	Moderate Limited	Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. (See also RC.02.01.01, EP 2)	1). Observed in Record Review at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . In the review of the record of patient receiving moderate sedation in the Emergency Department, there was no evidence that an airway assessment performed as part of the pre-sedation assessment. ASA score and dentition was documented. This was confirmed by the ED manager and ED Director.		
PC.03.05.15	1	Low Limited	Documentation of restraint and seclusion in the medical record includes the following: - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior - A description of the patient's behavior and the intervention used - Any alternatives or other less restrictive interventions attempted - The patient's condition or symptom(s) that warranted the use of the restraint or seclusion - The patient's response to the intervention(s) used, including the rationale for continued use of the intervention - Individual patient assessments and reassessments - The intervals for monitoring - Revisions to the plan of care - The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion - Injuries to the patient - Death associated with the use of restraint or seclusion - The identity of the physician, clinical psychologist, or other licensed independent practitioner who ordered the restraint or seclusion - Orders for restraint or seclusion - Notification of the use of restraint or seclusion to	1). Observed in Record Review at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . In the ED, there was an order in the medical record for nylon restraints. The order did not state the location of the restraints. The patient had restraints on both arms and both legs documented. This was confirmed by the ED Director.	§482.13(e)(16)(iv)	Standard

Supplemental #2 1
June 27, 2018
11:31 A.M.

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			the attending physician - Consultations Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).			
PC.04.01.05	7	Low Limited	The hospital educates the patient, and also the patient's family when it is involved in decision making or ongoing care, about how to obtain any continuing care, treatment, and services that the patient will need.	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . In the Cath Lab post procedure area, there was no evidence that a discharged patient was provided with education regarding ongoing care following a procedure involving moderate sedation. This was confirmed by the staff RN and manager. In the discharge instructions routinely given patients, moderate sedation ongoing care was not addressed.	§482.43(c)(5)	Standard
RI.01.01.03	1	Moderate Limited	The hospital provides information in a manner tailored to the patient's age, language, and ability to understand. (See also PC.02.01.21, EP 2; RI.01.01.01, EPs 2 and 5)	1). Observed in Individual Tracer at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During individual tracer activity of a surgical patient, it was observed that a patient whose language preference was Spanish had a procedure consent that was written in English and there was no documentation of using an interpreter.		
TS.03.01.01	7	Moderate Widespread	The hospital verifies at the time of receipt that package integrity is met and transport temperature range was controlled and acceptable for tissues requiring a controlled environment. This verification is documented. (See also TS.03.02.01, EP 6) Note 1: If the distributor uses validated shipping containers, then the receiver may document that the shipping container was received undamaged and within the stated time frame. Note 2: Tissues requiring no greater control than "ambient temperature" (generally defined as the temperature of the immediate environment) for transport and storage would not need to have the temperature verified on receipt.	1). Observed in Document Review at Saint Thomas West Hospital (4220 Harding Road, Nashville, TN) site . During tracer activity in Tissue Tracking, it was observed that documentation of receipt of the tissue as well as the package integrity and temperature integrity (for frozen tissue) was not started at the docking area which is where the tissue is received.		

The Joint Commission

Appendix

Conditions of Participation Text

Program: Hospital

CoP	Tag	CoP Standard text
§482.13 Condition of Participation: Patient's Rights	A-0115	§482.13 Condition of Participation: Patient's Rights A hospital must protect and promote each patient's rights.
§482.13(e)(16)(iv) Standard: Restraint or seclusion	A-0187	[When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:] (iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion.
§482.23 Condition of Participation: Nursing Services	A-0385	§482.23 Condition of Participation: Nursing Services The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.
§482.23(c)(3) Standard: Preparation and Administration of Drugs	A-0406	(3) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders in accordance with State law and hospital policy, and who is responsible for the care of the patient as specified under §482.12(c).
§482.41 Condition of Participation: Physical Environment	A-0700	§482.41 Condition of Participation: Physical Environment The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.
§482.41(a) Standard: Buildings	A-0701	§482.41(a) Standard: Buildings The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
§482.41(b)(1)(i) Standard: Life Safety from Fire	A-0710	(i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.
§482.42 Condition of Participation: Infection Control	A-0747	§482.42 Condition of Participation: Infection Control The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP	Tag	CoP Standard text
§482.42(a) Standard: Organization and Policies	A-0748	§482.42(a) Standard: Organization and Policies (a) Standard: Organization and policies. A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.
§482.43 Condition of Participation: Discharge Planning	A-0799	§482.43 Condition of Participation: Discharge Planning The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.
§482.43(c)(5) Standard: Discharge Plan	A-0820	(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post -hospital care.
§482.51 Condition of Participation: Surgical Services	A-0940	§482.51 Condition of Participation: Surgical Services If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.
§482.12 Condition of Participation: Governing Body	A-0043	§482.12 Condition of Participation: Governing Body There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.
§482.12(e) Standard: Contracted Services	A-0083	§482.12(e) Standard: Contracted Services The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.
§482.12(e)(1) Standard: Contracted Services	A-0084	(1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.

The Joint Commission

Appendix

Standard and EP Text

Program: Hospital

Standard	EP	Standard Text	EP Text
EC.02.01.01	5	The hospital manages safety and security risks.	The hospital maintains all grounds and equipment.
EC.02.05.01	9	The hospital manages risks associated with its utility systems.	The hospital labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.
IC.02.01.01	2	The hospital implements its infection prevention and control plan.	The hospital uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. (See also EC.02.02.01, EP 4) Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).
IC.02.02.01	2	The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.	The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4) Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes. Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

The Joint Commission

Standard	EP	Standard Text	EP Text
IC.02.02.01	4	The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.	The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.
LD.04.01.05	4	The hospital effectively manages its programs, services, sites, or departments.	Staff are held accountable for their responsibilities.
LD.04.03.09	5	Care, treatment, and services provided through contractual agreement are provided safely and effectively.	Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it.
LD.04.03.09	6	Care, treatment, and services provided through contractual agreement are provided safely and effectively.	Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations.
LS.02.01.10	14	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.	The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material. Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text, refer to NFPA 101-2012: 8.3.5)
LS.02.01.20	10	The hospital maintains the integrity of the means of egress.	New stairs serving three or more stories and existing stairs serving five or more stories have signs on each floor landing in the stairwell that identify the story, the stairwell, the top and bottom, and the direction to and story of exit discharge. Floor level information is also presented in tactile lettering. The signs are placed five feet above the floor landing in a position that is easily visible when the door is open or closed. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.2.2.5.4)
LS.02.01.20	14	The hospital maintains the integrity of the means of egress.	Exits, exit accesses, and exit discharges (means of egress) are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text, refer to NFPA 101-2012: 18/19.2.5.1; 7.1.10.1; 7.5.1.1) Note 1: Wheeled equipment (such as equipment and carts currently in use, equipment used for patient lift and transport, and medical emergency equipment not in use) that maintains at least five feet of clear and unobstructed corridor width is allowed, provided there is a fire plan and training program addressing its relocation in a fire or similar emergency. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (4)) Note 2: Where the corridor width is at least eight feet and the smoke compartment is fully protected by an electrically supervised smoke detection system or is in direct supervision of facility staff, furniture that is securely attached is allowed provided it does not reduce the corridor width to less than six feet, is only on one side of the corridor, does not exceed 50 square feet, is in groupings spaced at least 10 feet apart, and does not restrict access to building service and fire protection equipment. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (5))

The Joint Commission

Standard	EP	Standard Text	EP Text
LS.02.01.35	4	The hospital provides and maintains systems for extinguishing fires.	Piping for approved automatic sprinkler systems is not used to support any other item. (For full text, refer to NFPA 25-2011: 5.2.2.2)
LS.02.01.35	14	The hospital provides and maintains systems for extinguishing fires.	The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012: 18/19.3.5.
MM.04.01.01	13	Medication orders are clear and accurate.	The hospital implements its policies for medication orders.
PC.01.02.07	7	The hospital assesses and manages the patient's pain and minimizes the risks associated with treatment.	The hospital reassesses and responds to the patient's pain through the following: - Evaluation and documentation of response(s) to pain intervention(s) (See also RC.01.01.01, EP 7) - Progress toward pain management goals including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control) - Side effects of treatment - Risk factors for adverse events caused by the treatment
PC.02.01.11	2	Resuscitation services are available throughout the hospital.	Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)
PC.02.02.03	11	The hospital makes food and nutrition products available to its patients.	The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.
PC.03.01.03	1	The hospital provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.	Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. (See also RC.02.01.01, EP 2)
PC.03.05.15	1	The hospital documents the use of restraint or seclusion.	Documentation of restraint and seclusion in the medical record includes the following: - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior - A description of the patient's behavior and the intervention used - Any alternatives or other less restrictive interventions attempted - The patient's condition or symptom(s) that warranted the use of the restraint or seclusion - The patient's response to the intervention(s) used, including the rationale for continued use of the intervention - Individual patient assessments and reassessments - The intervals for monitoring - Revisions to the plan of care - The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion

Standard	EP	Standard Text	EP Text
			- Injuries to the patient - Death associated with the use of restraint or seclusion - The identity of the physician, clinical psychologist, or other licensed independent practitioner who ordered the restraint or seclusion - Orders for restraint or seclusion - Notification of the use of restraint or seclusion to the attending physician - Consultations Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
PC.04.01.05	7	Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, and services.	The hospital educates the patient, and also the patient's family when it is involved in decision making or ongoing care, about how to obtain any continuing care, treatment, and services that the patient will need.
RI.01.01.03	1	The hospital respects the patient's right to receive information in a manner he or she understands.	The hospital provides information in a manner tailored to the patient's age, language, and ability to understand. (See also PC.02.01.21, EP 2; RI.01.01.01, EPs 2 and 5)
TS.03.01.01	7	The hospital uses standardized procedures for managing tissues.	The hospital verifies at the time of receipt that package integrity is met and transport temperature range was controlled and acceptable for tissues requiring a controlled environment. This verification is documented. (See also TS.03.02.01, EP 6) Note 1: If the distributor uses validated shipping containers, then the receiver may document that the shipping container was received undamaged and within the stated time frame. Note 2: Tissues requiring no greater control than "ambient temperature" (generally defined as the temperature of the immediate environment) for transport and storage would not need to have the temperature verified on receipt.

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

The Joint Commission

Official Accreditation Report

TrustPoint Hospital LLC
1009 N. Thompson Ln.
Murfreesboro, TN 37129

Organization Identification Number: 528362

Unannounced Full Event: 9/9/2015 - 9/10/2015

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Supplemental #1
June 27, 2018
11:31 A.M.

The Joint Commission

~~Supplemental #1~~
March 27, 2018
11:42 am

Executive Summary

Program(s)	Survey Date(s)
Hospital Accreditation	09/09/2015-09/10/2015

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.04.01.01	EP15
	PC.02.01.11	EP2
	RI.01.03.01	EP9

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.01.01.01	EP3
	EC.02.03.05	EP13,EP18,EP20
	EC.04.01.03	EP3
	EM.02.02.11	EP3
	EM.03.01.01	EP2,EP4
	LD.04.01.05	EP4
	LD.04.04.01	EP25
	MS.06.01.03	EP3
	PC.01.02.03	EP5
	RC.01.02.01	EP4

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(b)(2)	A-0131	HAP - RI.01.03.01/EP9	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(2)	A-0450	HAP - RC.01.02.01/EP4	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.03.05/EP13, EP18, EP20; EC.04.01.01/EP15	Standard
§482.41(a)	A-0701	HAP - EC.01.01.01/EP3, EM.02.02.11/EP3	Standard

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)(1)(i)	A-0952	HAP - PC.01.02.03/EP5	Standard

Supplemental #1
June 27, 2018
11:31 A.M.

The Joint Commission
Summary of CMS Findings

Supplemental #1
March 27, 2018
11:42 am

CoP: §482.22 **Tag:** A-0338 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(1)	A-0340	HAP - MS.08.01.03/EP3	Standard

Requirements for Improvement – Detail

Chapter: Emergency Management
Program: Hospital Accreditation
Standard: EM.02.02.11 ESC 60 days
Standard Text: As part of its Emergency Operations Plan, the hospital prepares for how it will manage patients during emergencies.

Element(s) of Performance:

3. The Emergency Operations Plan describes the following: How the hospital will evacuate (from one section or floor to another within the building, or, completely outside the building) when the environment cannot support care, treatment, and services. (See also EM.02.02.03, EPs 9 and 10)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This Standard is NOT MET as evidenced by:
Observed in Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
The hospitals EOP and it's *Fire plan does not address how the hospital will evacuate to the outside of the building when the environment cannot support care, treatment, and services.*

Chapter: Emergency Management
Program: Hospital Accreditation
Standard: EM.03.01.01 ESC 60 days
Standard Text: The hospital evaluates the effectiveness of its emergency management planning activities.

Element(s) of Performance:

2. The hospital conducts an annual review of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented.

Scoring Category : A
Score : Insufficient Compliance

4. The annual emergency management planning reviews are forwarded to senior hospital leadership for review. (See also LD.04.04.01, EP 25)
Note: Senior hospital leadership refers to those leaders with responsibility for organizationwide strategic planning and budgets (vice presidents and officers). The hospital may determine that all senior hospital leaders participate in reviewing emergency management reviews, or it may designate specific senior hospital leaders to review this information.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.
For 2014 and the first 8 months of 2015 - The hospital has not conducted an annual review of the objectives and scope of its Emergency Operations Plan

EP 4
Observed in Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.
For 2014 and the first 8 months of 2015 - The hospital has not conducted an annual review of the objectives and scope of its Emergency Operations Plan. Therefore the annual emergency management planning review has not been forwarded to senior hospital leadership for review.

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.01.01.01 ESC 60 days
Standard Text: The hospital plans activities to minimize risks in the environment of care.
Note: One or more persons can be assigned to manage risks associated with the management plans described in this standard.

Element(s) of Performance:

3. The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital's facilities. (See also EC.04.01.01, EP 15)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This Standard is NOT MET as evidenced by:
Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In reviewing the Safety Management Plan (Policy 15.053) presented to this surveyor, the plan appears to be directly copied from another Hospital and is not accurate for this hospital.. Example -The Safety Management Plan is dated "reviewed in 12/10/2010" - However this hospital did not open till 2012.

Also in section B-1-e,f,and g the Safety Plan discusses activities to be done by a Texas regulatory authorities Note, This hospital is located in Murfreesboro TN

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.03.05 EXC 60 days
Standard Text: The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

Element(s) of Performance:

13. Every 6 months, the hospital inspects any automatic fire-extinguishing systems in a kitchen. The completion dates of the inspections are documented.
Note 1: Discharge of the fire-extinguishing systems is not required.
Note 2: For additional guidance on performing inspections, see NFPA 96, 1998 edition.

Scoring Category : A
Score : Insufficient Compliance

18. The hospital operates fire and smoke dampers 1 year after installation and then at least every 6 years to verify that they fully close. The completion date of the tests is documented.
Note 1: The initial test that must occur 1 year after installation applies only to dampers installed on and after January 1, 2008.
Note 2: For additional guidance, see NFPA 80 Standard for Fire Doors and Other Opening Protectives, 2007 edition (Section 19.4.1.1) and NFPA 105, 2007 edition (Section 6.5.2).

Scoring Category : C
Score : Partial Compliance

20. Every 12 months, the hospital tests sliding and rolling fire doors for proper operation and full closure. The completion date of the tests is documented.
Note: For additional guidance on performing tests, see NFPA 80, 1999 edition (Section 15-2.4).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 13
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
For 2014 and 2015 - The hospital's documentation indicates that the kitchen hood extinguishment system was tested on 4/15, 7/14 and 4/14, which is 3 months and 9 months apart, not every 6 months as required by the standard.

EP 18
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
For the 1st floor - The hospital had it's initial (new installation) fire damper inspection during 7/2012. The hospital does not have documentation that it conducted a 1 year after installation, fire and smoke damper test and inspection.

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
For the 2nd floor - The hospital had it's initial (new installation) fire damper inspection during 7/2012. The hospital does not have documentation that it conducted a 1 year after installation, fire and smoke damper test and inspection.

EP 20
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
For 2013 and 2014 - The hospital does not have documentation that annually it has conducted a test and inspection of it's 2 rolling fire doors. (dish room and loading dock)

Chapter:	Environment of Care
Program:	Hospital Accreditation
Standard:	EC.04.01.01 ESC 45 days
Standard Text:	The hospital collects information to monitor conditions in the environment.

Supplemental #2
June 27, 2018
11:31 A.M.

Supplemental #1
March 27, 2018
11:42 am

Element(s) of Performance:

15. Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. (See also EC.01.01.01, EPs 3-8; EC.04.01.03, EP 1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 15
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - The Security Management plan review section "Security Management Plan Includes" discussed information from 2012 and activities to be implemented in 2013. There is no information for 2014 in this section.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - The Security Management Plan review section "Traffic Control" discusses Controlling access to the ER, OR, Peds. and Nursery. This hospital does not have these departments.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - The Hazardous Materials Plan review section "Hazardous Materials Inventory" discusses actions related to a MSDS program to be implemented and evaluated in 2013. There is no information or data for 2014.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - Utility Management Plan review section "Emergency Generator Testing" The review states the generator was tested under "50% full connected load each month". However during the review of the generator test records earlier in the survey with the hospital's engineer, it was noted that the generator does not always meet 30% load and therefore the hospital must do an annual load bank test.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - Under the review section "Miscellaneous" the review discusses the 2012 and 2013 PII actions but there is no information related to a 2014 PII project.

Chapter:	Environment of Care
Program:	Hospital Accreditation
Standard:	EC.04.01.03
Standard Text:	The hospital analyzes identified environment of care issues.

ESC 60 days

Element(s) of Performance:

3. Annually, representatives from clinical, administrative, and support services recommend one or more priorities for improving the environment of care.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.
In reviewing the hospitals Annual review of it's management plans for the year 2014 - The review discusses 2012 and 2013 PII actives but there is no information or data related to clinical, administrative, and support services recommending one or more priorities for improving the environment of care during 2014 or for PII activities to be conducted during 2015.

Chapter: Leadership
Program: Hospital Accreditation
Standard: LD.04.01.05 ESC 60 days
Standard Text: The hospital effectively manages its programs, services, sites, or departments.

Element(s) of Performance:

4. Staff are held accountable for their responsibilities.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.
Staff are not held accountable for their responsibilities, as indicated by Life Safety findings at Standard EC 02.03.05, EPs 13, 18 and 20.

The Joint Commission

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.04.01 ESC 60 days

Standard Text: Leaders establish priorities for performance improvement. (Refer to the 'Performance Improvement' [PI] chapter.)

Element(s) of Performance:

25. Senior hospital leadership directs implementation of selected hospitalwide improvements in emergency management based on the following:
- Review of the annual emergency management planning reviews (See also EM.03.01.01, EP 4)
- Review of the evaluations of all emergency response exercises and all responses to actual emergencies (See also EM.03.01.03, EP 15)
- Determination of which emergency management improvements will be prioritized for implementation, recognizing that some emergency management improvements might be a lower priority and not taken up in the near term

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 25

Observed in Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.
For 2014 and the first 8 months of 2015 - The hospital has not conducted an annual review of the objectives and scope of its Emergency Operations Plan. Therefore the annual emergency management planning review has not been forwarded to senior hospital leadership for review. This prevents senior leadership from directing implementation of selected hospital wide improvements in emergency management

---

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.08.01.03 ESC 60 days

Standard Text: Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

Element(s) of Performance:

3. The process for the ongoing professional practice evaluation includes the following: Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.
This Standard is NOT MET as evidenced by:
Observed in Medical Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In discussion with the medical staff office and review of physicians files, it was observed the OPPE process did not begin until April,2015. The hospital opened in 2012, therefore the reappointment process for physicians did not include OPPE data in 2014.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.03

ESC 60 days

Standard Text: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

Element(s) of Performance:

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 5
§482.51(b)(1)(i) - (A-0952) - (i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
Noted on the chart the anesthesia's history and physical update was not completed.

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In tracer activity and review of the record, noted the anesthesia history and physical updated was not completed.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.11 ESC 45 days

Standard Text: Resuscitation services are available throughout the hospital.

Element(s) of Performance:

2. Resuscitation equipment is available for use based on the needs of the population served.
Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.
Noted resuscitative equipment on the medical psychiatric unit had not been checked in a manner consistent with organization policy on 9/2 and 9/4. On 9/4 a defibrillator strip was posted, but there was no documentation that the suction, oxygen tank or crash cart lock had been checked. On 9/2 there was not documentation that any of the resuscitative equipment had been checked.

Chapter: Record of Care, Treatment, and Services

The Joint Commission

Program: Hospital Accreditation

Standard: RC.01.02.01

ESC 60 days

Standard Text: Entries in the medical record are authenticated.

Element(s) of Performance:

4. Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author.
Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.
Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date -stamped.
Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 4
§482.24(c)(2) - (A-0450) - (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In review of the medical record during tracer activity, progress notes by the physician were not being signed in the time frame defined by hospital policy.

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In tracer activity, noted the progress notes written by the attending physician were not signed in the time frame defined by policy.

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In review of the medical review ,noted the psychiatric evaluation was not signed in the time frame defined by policy.

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
During review of medical record of patient who was placed in behavioral restraints noted physician did not authenticate telephone order for restraints. Organization policy #: NUR 0012: Restraint and Seclusion, revision date 12/21/13, required the ordering physician to personally sign, time and date the telephone order within 24 hours of the time the order was originally issued.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01 ESC 45 days

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

Element(s) of Performance:

9. The informed consent process includes a discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 9
§482.13(b)(2) - (A-0131) - (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In tracer activity and review if the clinical chart, noted there was not any documentation in the record that the anesthesiologist had a discussion with the patient or family members, about the risks, benefits, side effects of the proposed anesthesia treatment

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.
In discussion with the staff and review of the medical record on a patient who received a PICC line, there was not any documentation by the physician about the risks of the proposed treatment.

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program:	Hospital Accreditation Program	
Standards:	EC.02.06.01	EP1
	IC.02.02.01	EP4
	LS.02.01.10	EP5
	LS.02.01.30	EP18
	LS.02.01.35	EP4
	MM.05.01.01	EP8
	NPSG.15.01.01	EP1,EP2
	PC.01.03.01	EP23

Opportunities for Improvement – Detail

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.06.01
Standard Text: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP1
Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. During tracer on medical psychiatric unit noted patient identified as suicidal was housed in a non-ligature proof room. The room has an extended shower head and sink faucet in addition to a standard hospital bed and call bell cords. Patient was transferred to the adult psychiatric unit on the second floor.

Chapter: Infection Prevention and Control
Program: Hospital Accreditation
Standard: IC.02.02.01
Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Element(s) of Performance:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

The Joint Commission
Findings

EP4
Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. During tracer on medical psychiatric unit noted two blood collection tubes that expired 8/15 and were stored ready for use in a mobile blood drawing tray.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Element(s) of Performance:

5. Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1 -11.4)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP5
Observed in Building Tour at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. Main electrical room - the gap between the meeting edges of the double, 1 hour rated fire doors is over 1/8 inch.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Element(s) of Performance:

18. Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.3)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP18
Observed in Building Tour at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. Above the smoke doors in the hall to the Senior unit. There is an un sealed penetration in the smoke wall. Note - this was repaired during the survey.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.35

Standard Text: The hospital provides and maintains systems for extinguishing fires.

Element(s) of Performance:

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP4
Observed in Building Tour at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. Above the double smoke doors by the Private Dining room - A large bundle of IT wiring has been plastic cable tied to the sprinkler piping..

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.05.01.01

Standard Text: A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

The Joint Commission
Findings

Element(s) of Performance:

8. All medication orders are reviewed for the following: Therapeutic duplication.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP8
Observed in Tracer Activities at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. Noted in the medical record during tracer activity, two pain medications were ordered without clear guidelines to the nursing staff on which medication to use first.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.15.01.01

Standard Text: Identify patients at risk for suicide.
Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Element(s) of Performance:

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.

Scoring Category : C
Score : Satisfactory Compliance

2. Address the patient's immediate safety needs and most appropriate setting for treatment.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

The Joint Commission
Findings

Supplemental #1
March 27, 2018
11:42 am

EP1
Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. During tracer on medical psychiatric unit noted risk assessment that identified specific environmental features that may increase the risk of suicide was not completed prior to or during a period in which a suicidal patient was housed on the unit. A total of 12 small and large nail clippers, and two one quart bottles of cleaning solution were stored in unlocked cabinets in an area that was not supervised 100% of the time and was easily accessible via the main hallway used by patients and anyone entering the unit.
EP2
Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. During a tracer on the medical psychiatric unit staff were not able to verbalize a coherent plan to accomplish the every 15 minute checks required by the organization to keep a suicidal patient housed on their unit safe. A video camera was in use in the patient room, but the camera outputs were not being continuously monitored or recorded for future review.

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.01.03.01
Standard Text: The hospital plans the patient's care.

Element(s) of Performance:

23. The hospital revises plans and goals for care, treatment, and services based on the patient's needs. (See also RC.02.01.01, EP 2)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP23
Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. During tracer on medical psychiatric unit noted nursing care plans in 3 of 4 patient records reviewed did not reflect active medical or psychosocial issues identified during assessment.

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 0

Supplemental #2
June 27, 2018
11:31 A.M.

301

Supplemental #2
March 29, 2018
11:59 A.M.

TN Department of Health

February 6, 2018

Mr. Jeffery Woods, Administrator
Trustpoint Hospital
1009 North Thompson Ln
Murfreesboro TN 37129

RE: TNP531184

Dear Mr. Woods:

The East Tennessee Regional Office of Health Care Facilities conducted a Life Safety construction visit on November 29, 2017. A desk review was conducted, based on that review; we are accepting your plan of correction and are assuming that your facility is in compliance with all regulations cited as of December 12, 2017.

If you have any questions, please contact this office at (865) 594-9396 or by facsimile at (865) 594-5739.

Sincerely,

Tamra Turberville/cw

Tamra Turberville, RN, MSN
Public Health Regional Regulatory Program Manager

TT:cw

Supplemental #1
June 27, 2018
11:31 A.M.

The Joint Commission

Official Accreditation Report

Saint Thomas River Park Hospital, LLC
1559 Sparta Road
McMinnville, TN 37110

Organization Identification Number: 7866

Unannounced Full Event: 5/10/2016 - 5/13/2016

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Executive Summary

Program(s)	Survey Date(s)
Hospital Accreditation	05/10/2016-05/13/2016

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program		
Standards:	PC.02.01.03	EP1	no MOS

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program		
Standards:	EC.02.03.03	EP1	no MOS for any RFI
	EC.02.03.05	EP1	
	LS.02.01.10	EP9	
	LS.02.01.20	EP30	

The Joint Commission
Summary of CMS Findings

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.03.05/EP1	Standard
§482.41(b)(1)(i)	A-0710	HAP - EC.02.03.03/EP1, LS.02.01.10/EP9, LS.02.01.20/EP30	Standard

---

CoP: §482.57 **Tag:** A-1151 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.57 Condition of Participation: Respiratory Care Services

The hospital must meet the needs of the patients in accordance with acceptable standards of practice. The following requirements apply if the hospital provides respiratory care services.

CoP Standard	Tag	Corresponds to	Deficiency
§482.57(b)(3)	A-1163	HAP - PC.02.01.03/EP1	Standard

Requirements for Improvement – Detail

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.03

ESC 60 days

Standard Text: The hospital conducts fire drills.

Element(s) of Performance:

1. The hospital conducts fire drills once per shift per quarter in each building defined as a health care occupancy by the Life Safety Code. The hospital conducts quarterly fire drills in each building defined as an ambulatory health care occupancy by the Life Safety Code. (See also LS.01.02.01, EP 11; LS.02.01.70, EP 4; LS.03.01.70, EP 6)
Note 1: Evacuation of patients during drills is not required.
Note 2: In leased or rented facilities, drills need be conducted only in areas of the building that the hospital occupies.

4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Document Review at Saint Thomas River Park Hospital, LLC (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.
In review of fire drill documentation for the previous five quarters, encompassing 2015 and 2016 to date, there was no fire drill conducted on the third shift during the fourth quarter of 2015. It was confirmed by the hospital team that there were two done on the second shift and the third shift had been missed.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.05 ESC 60 days

Standard Text: The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

Element(s) of Performance:

1. At least quarterly, the hospital tests supervisory signal devices (except valve tamper switches). The completion date of the tests is documented.
Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2). 4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:

Observed in Document Review at Saint Thomas River Park Hospital, LLC (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.
At the time of survey, the hospital did not have documentation of the supervisory signals for the low air pressure alarm on the dry pipe system having been tested quarterly as required.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10 ESC 60 days

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Element(s) of Performance:

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 9
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at Saint Thomas River Park Hospital, LLC (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.
In 2 of 10 above ceiling checks, penetrations in rated fire walls were not properly sealed. The space around a cable within a 3/4" conduit sleeve above the ceiling in the one-hour-rated fire and smoke wall at the entrance to the inpatient unit was not properly sealed with an intumescent fire stop system. The space was sealed with joint compound. The spaces around cables penetrating the one-hour-rated fire and smoke wall at two locations above the ceiling by room 209 were likewise sealed with joint compound.

Chapter: Life Safety
Program: Hospital Accreditation
Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.
Element(s) of Performance:

30. Signs reading 'No Exit' are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text and any exceptions, refer to NFPA 101 -2000: 7.10.8.1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 30
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at Saint Thomas River Park Hospital, LLC (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.
The "Level One Rehab Stair" could be mistaken for an exit stair from the first floor, but is not. At the time of survey, it lacked a "No Exit" sign. This was observed but corrected on site.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.03

ESC 45 days

Standard Text: The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. *
Note: Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:
- Responsible for the care of the patient
- Licensed to practice in the state where he or she provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements
- Acting within his or her scope of practice under state law
- Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services
Footnote *: For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.57(b)(3) - (A-1163) - (3) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.
This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at Saint Thomas River Park Hospital, LLC (1559 Sparta Road, Mc Minnville, TN) site for the Hospital deemed service.
57 yo female transported from home to ED on March 12, 2015 at 9:15am with shortness of breath, oxygen saturation 50% and cyanotic. Patient was intubated at (first attempt) at 9:50am. Ventilator settings: Assist control, Tidal volume 600, Rate 16, Fi02 60% with PEEP 3. There was no documentation of initial ventilator settings as initial time of intubation. At 10:55 order to decrease Tidal volume to 500, the Respiratory Therapist made the change in the Tidal volume at 10:56.

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP5
	IC.02.01.01	EP1
	IM.02.01.03	EP6
	LS.02.01.10	EP5
	LS.02.01.30	EP2
	LS.02.01.35	EP4,EP6,EP14
	PC.01.02.07	EP3
	PC.01.03.01	EP22
	PC.03.05.15	EP1

Opportunities for Improvement – Detail

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.02.01
Standard Text: The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance:

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP5
Observed in Building Tour at Saint Thomas River Park Hospital, LLC (1559 Sparta Road,Mc Minnville,TN) site.
At the time of survey, the hospital team confirmed that the shower and hand-held spray shower in the patient decontamination room at the entrance to the Emergency Department was not routinely flowed on a preventive basis. This hand-held spray and shower should be flowed weekly as has currently been being done for the emergency showers and eyewashes at other locations in the facility.

Chapter: Infection Prevention and Control
Program: Hospital Accreditation
Standard: IC.02.01.01
Standard Text: The hospital implements its infection prevention and control plan.

Element(s) of Performance:

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP1
Observed in Tracer Activities at Saint Thomas River Park Hospital, LLC (1559 Sparta Road,Mc Minnville,TN) site.
During the tour of the Inpatient Rehab Unit, the room equipped with a washer and dryer was noted. Patients' clothing are laundered by the staff or the Inpatient Rehab and Behavioral patients. The hospital's policy- Infection Control-ADL Washer and Dryer states:"The washer and dryer shall be used by the rehabilitation unit staff or training purposes and for cleaning rehabilitation patient personal clothing. The procedure statement reads "Disinfectant shall be used with each day at the end of the day. The Washing and Machine Cleaning Record is used to log the daily cleaning of the washer and dryer. Review of the log shows May 2, May 4 and May 5, the washer was bleach water run- the comment by the dates is "no bleach available. This practice is not in compliance with the hospital's policy. This issue was addressed during the course of the survey.

Chapter: Information Management

Program: Hospital Accreditation

Standard: IM.02.01.03

Standard Text: The hospital maintains the security and integrity of health information.

Element(s) of Performance:

6. The hospital protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP6
Observed in Individual Tracer at Saint Thomas River Park Hospital, LLC (1559 Sparta Road,Mc Minnville,TN) site.
Documentation error in the medical record was not performed in a manner consistent with policy- Saint Thomas River Park Hospital titled Chart Analysis, Procedure section. statement C which reads: All documentation error must be addressed in writing as "error" and initialed. The Intake Coordinator did not correct the documentation error as outlined in the hospital's policy.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Element(s) of Performance:

5. Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1-11.4)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP5
Observed in Building Tour at Saint Thomas River Park Hospital, LLC (1559 Sparta Road,Mc Minnville,TN) site.
At the time of survey, the gap between the ninety-minute-rated fire doors in the two-hour-rated fire wall separating the business occupancy ("MOB") from the healthcare occupancy (hospital) exceeded 1/8 inch, up to 1/4 inch at the "widest" point at the bottom of the doors.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Element(s) of Performance:

2. All hazardous areas are protected by walls and doors in accordance with NFPA 101-2000: 18/19.3.2.1. (See also LS.02.01.10, EP 5; LS.02.01.20, EP 18) Hazardous areas include, but are not limited, to the following:
Boiler/fuel-fired heater rooms
- Existing boiler/fuel-fired heater rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New boiler/fuel-fired heater rooms have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
Central/bulk laundries larger than 100 square feet
- Existing central/bulk laundries larger than 100 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laundries have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New central/bulk laundries larger than 100 square feet have sprinkler systems and have 1-hour fire-

rated walls and 3/4-hour fire-rated doors.
Flammable liquid storage rooms (See NFPA 30-1996:4-4.2.1 and 4-4.4.2)
- Existing flammable liquid storage rooms have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
- New flammable liquid storage rooms have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
Laboratories (See NFPA 45-1996 to determine if a laboratory is a 'severe hazard' area)
- Existing laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laboratories have walls fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- Existing laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. When there is a sprinkler system, the walls are fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- Existing flammable gas storage rooms in laboratories have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)
- New flammable gas storage rooms in laboratories have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)
Maintenance repair shops
- Existing maintenance repair shops have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with at least 3/4-hour fire-rated doors.
- New maintenance repair shops have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Piped oxygen tank supply rooms (See NFPA 99-1999: 4-3.1.1.2)
- Existing piped oxygen tank supply rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New piped oxygen tank supply rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Paint shops that are not severe hazard areas
- Existing paint shops that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-

hour fire-rated walls with 3/4-hour fire-rated doors.
- New paint shops that are not severe hazard areas have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Soiled linen rooms
- Existing soiled linen rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New soiled linen rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Storage rooms
- Existing storage rooms for combustible materials larger than 50 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New storage rooms for combustible materials 50 to 100 square feet are sprinklered, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- New storage rooms for combustible materials larger than 100 square feet are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Trash collection rooms
- Existing trash collection rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New trash collection rooms are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in Building Tour at Saint Thomas River Park Hospital, LLC (1559 Sparta Road,Mc Minnville,TN) site.
At the time of survey, the "back" door to the Pharmacy, a hazardous area with over one hundred square feet of combustible storage, was in need of adjustment, rendering it to not be fully self-closing and positive-latching.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.35

Standard Text: The hospital provides and maintains systems for extinguishing fires.

The Joint Commission
Findings

Element(s) of Performance:

14. The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2000: 18/19.3.5.

Scoring Category : C
Score : Satisfactory Compliance

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)

Scoring Category : C
Score : Satisfactory Compliance

6. There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage.
Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text and any exceptions, refer to NFPA 13-1999: 5-8.5.2.1)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP14
Observed in Building Tour at Saint Thomas River Park Hospital, LLC (1559 Sparta Road,Mc Minnville,TN) site.
At the time of survey, there was a total of approximately forty-five square inches of unsealed space around conduits penetrating the ceiling tiles in the second floor Communications Room by Administration, negatively impacting the function of the smoke detector and sprinkler in the room.
EP4
Observed in Building Tour at Saint Thomas River Park Hospital, LLC (1559 Sparta Road,Mc Minnville,TN) site.
At the time of survey, there was an approximately three-inch bundle of cables being supported by the sprinkler pipe above the ceiling near the chapel.
EP6
Observed in Building Tour at Saint Thomas River Park Hospital, LLC (1559 Sparta Road,Mc Minnville,TN) site.
At the time of survey, there was storage located below one of the fifteen sprinklers in the main storeroom what was less than eighteen inches below the plane of the sprinkler deflectors, at approximately nine inches below the sprinkler.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.07

Standard Text: The hospital assesses and manages the patient's pain.

Element(s) of Performance:

3. The hospital reassesses and responds to the patient's pain, based on its reassessment criteria.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP3
Observed in Record Review at Saint Thomas River Park Hospital, LLC (1559 Sparta Road,Mc Minnville,TN) site.
During closed record review of patient (male) presented to ED after falling at home. For pain he described as a 5 on a numeric pain scale (1-10) 15 mg of Toradol was administered at 14;14 The medication order was Toradol 15mg IV IX1ED STA. The patient underwent left shoulder reduction; he was discharged 14;44. Pain reassessment was not documented

---

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.01.03.01
Standard Text: The hospital plans the patient's care.

Element(s) of Performance:

22. Based on the goals established in the patient's plan of care, staff evaluate the patient's progress.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP22
Observed in Individual Tracer at Saint Thomas River Park Hospital, LLC (1559 Sparta Road,Mc Minnville,TN) site.
During review of patient chart, evaluation of the established goals in the plan of care was not documented .

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.03.05.15
Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital documents the use of restraint or seclusion.

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: Documentation of restraint and seclusion in the medical record includes the following:
- Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior
- A description of the patient's behavior and the intervention used
- Any alternatives or other less restrictive interventions attempted
- The patient's condition or symptom(s) that warranted the use of the restraint or seclusion
- The patient's response to the intervention(s) used, including the rationale for continued use of the intervention
- Individual patient assessments and reassessments
- The intervals for monitoring
- Revisions to the plan of care
- The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion
- Injuries to the patient
- Death associated with the use of restraint or seclusion
- The identity of the physician, clinical psychologist, or other licensed independent practitioner who ordered the restraint or seclusion
- Orders for restraint or seclusion
- Notification of the use of restraint or seclusion to the attending physician
- Consultations

Note: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP1
Observed in Individual Tracer at Saint Thomas River Park Hospital, LLC (1559 Sparta Road,Mc Minnville,TN) site.
23 y o male presented to ED in crisis/danger to self in July 10, 2015 at 9:06am. He was placed in seclusion. Discrepancies in the documentation of the patient's behavior on the flow sheet and the narrative note. On the flow sheet the patient's behavior is documented as combative, the patient's behavior described in the narrative note as "resting head on the mom's lap,

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 19

Site: Saint Thomas River Park Hospital, LLC

Building Name: River Park Hospital_HAP

PFI Id: 309

Description:

In patient room 309 at smoke wall, hole approx. two ft. by one ft. on one side.

ILSM Access: Yes

Projected Completion Date: 5/31/2016

Funds Committed: Yes

Accepted Date: 5/12/2016

Site: Saint Thomas River Park Hospital, LLC

Building Name: River Park Hospital_HAP

PFI Id: 3A

Description:

Above ceiling at 3A double doors, wall void around pnuematic tube pipe

ILSM Access: Yes

Projected Completion Date: 6/2/2016

Funds Committed: Yes

Accepted Date: 5/12/2016

Site: Saint Thomas River Park Hospital, LLC

Building Name: River Park Hospital_HAP

PFI Id: 3A

Description:

Add sprinkler head above duct work in communication room level 3

ILSM Access: Yes

Projected Completion Date: 6/20/2016

Funds Committed: Yes

Accepted Date: 5/12/2016

Site: Saint Thomas River Park Hospital, LLC

Building Name: River Park Hospital_HAP

PFI Id: 3B Locker Ro

Description:

Intall door closure at 3B supply room to locker room

ILSM Access: Yes

Projected Completion Date: 6/20/2016

Funds Committed: Yes

Accepted Date: 5/12/2016

Site: Saint Thomas River Park Hospital, LLC

Building Name: River Park Hospital_HAP

PFI Id: 2 Nurses Sta

Description:

Sprinkler at window improper installation on Level 2

ILSM Access: Yes

Projected Completion Date: 6/20/2016

Funds Committed: Yes

Accepted Date: 5/12/2016

Site: Saint Thomas River Park Hospital, LLC

Building Name: River Park Hospital_HAP

PFI Id: 2 EL

Description:

Smoke detector in electrical room on level 2 needs relocated higher

ILSM Access:	Yes
Projected Completion Date:	6/20/2016
Funds Committed:	Yes
Accepted Date:	5/12/2016

Site:	Saint Thomas River Park Hospital, LLC
Building Name:	River Park Hospital_HAP
PFI Id:	2 Comm

Description:

No sprinkler head above duct work on level 2 at comm closet

ILSM Access:	Yes
Projected Completion Date:	6/20/2016
Funds Committed:	Yes
Accepted Date:	5/12/2016

Site:	Saint Thomas River Park Hospital, LLC
Building Name:	River Park Hospital_HAP
PFI Id:	2 Admin

Description:

No door closure on Administration Records Room

ILSM Access:	Yes
Projected Completion Date:	6/20/2016
Funds Committed:	Yes
Accepted Date:	5/12/2016

Site:	Saint Thomas River Park Hospital, LLC
Building Name:	River Park Hospital_HAP
PFI Id:	2 Admin

Description:

Administrative storage room missing door closure

ILSM Access:	Yes
Projected Completion Date:	6/20/2016
Funds Committed:	Yes
Accepted Date:	5/12/2016

Site: Saint Thomas River Park Hospital, LLC

Building Name: River Park Hospital_HAP

PFI Id: 1 Linen

Description:

Install additional sprinklers in linen room - EVS - and relocate top shelf

ILSM Access: Yes

Projected Completion Date: 6/20/2016

Funds Committed: Yes

Accepted Date: 5/12/2016

Site: Saint Thomas River Park Hospital, LLC

Building Name: River Park Hospital_HAP

PFI Id: B - MECH

Description:

Replace sprinkler heads in mechanical room – basement – covered with fire proofi

ILSM Access: Yes

Projected Completion Date: 6/27/2016

Funds Committed: Yes

Accepted Date: 5/12/2016

Site: Saint Thomas River Park Hospital, LLC

Building Name: River Park Hospital_HAP

PFI Id: 1 - TC

Description:

Sprinkler coverage missing - time clock storage room

ILSM Access: Yes

Projected Completion Date: 7/25/2016

Funds Committed: Yes

Accepted Date: 5/12/2016

Site: Saint Thomas River Park Hospital, LLC

Building Name: River Park Hospital_HAP

PFI Id: 3B Supply

Description:

Holes in door frames (2) and doors (2) at 3 B supply room

ILSM Access:	Yes
Projected Completion Date:	7/29/2016
Funds Committed:	Yes
Accepted Date:	5/12/2016

Site:	Saint Thomas River Park Hospital, LLC
Building Name:	River Park Hospital_HAP
PFI Id:	ICU

Description:

ICU doors not positive latching for suite integrity

ILSM Access:	Yes
Projected Completion Date:	7/29/2016
Funds Committed:	Yes
Accepted Date:	5/12/2016

Site:	Saint Thomas River Park Hospital, LLC
Building Name:	River Park Hospital_HAP
PFI Id:	1 - EL

Description:

Structural beam fire proofing missing - Elevator Room by elec room

ILSM Access:	Yes
Projected Completion Date:	8/31/2016
Funds Committed:	Yes
Accepted Date:	5/12/2016

Site:	Saint Thomas River Park Hospital, LLC
Building Name:	River Park Hospital_HAP
PFI Id:	2-IPRH

Description:

Bottom latching hardware at entrance to Inpatient Rehab

ILSM Access:	Yes
Projected Completion Date:	9/1/2016
Funds Committed:	Yes
Accepted Date:	5/12/2016

Site:	Saint Thomas River Park Hospital, LLC
Building Name:	River Park Hospital_HAP
PFI Id:	2-South/Nort
Description:	

Install bottom latching hardware at Level 2 South/North Doors

ILSM Access:	Yes
Projected Completion Date:	9/1/2016
Funds Committed:	Yes
Accepted Date:	5/12/2016

Site:	Saint Thomas River Park Hospital, LLC
Building Name:	River Park Hospital_HAP
PFI Id:	Smoot Classr
Description:	

At Smoot Classroom, install bottom latching hardware

ILSM Access:	Yes
Projected Completion Date:	9/1/2016
Funds Committed:	Yes
Accepted Date:	5/12/2016

Site:	Saint Thomas River Park Hospital, LLC
Building Name:	River Park Hospital_HAP
PFI Id:	104
Description:	

Sprinkler piping supporing two water lines at patient room 104

ILSM Access:	Yes
Projected Completion Date:	9/1/2016
Funds Committed:	Yes
Accepted Date:	5/12/2016

The Joint Commission

Official Accreditation Report

Saint Thomas Stones River Hospital, LLC
324 Doolittle Road
Woodbury, TN 37190

Organization Identification Number: 5198

Unannounced Full Event: 10/28/2015 - 10/30/2015

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Supplemental #2
June 27, 2018
11:31 A.M.

Executive Summary

Program(s)	Survey Date(s)
Hospital Accreditation	10/28/2015-10/30/2015

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	IC.02.02.01	EP2
	MM.04.01.01	EP13
	PC.02.02.03	EP11
	PC.03.01.03	EP1
	PC.03.01.07	EP7
	RC.01.01.01	EP8

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.01.01	EP5

The Joint Commission
Summary of CMS Findings

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(c)(3)	A-0406	HAP - MM.04.01.01/EP13	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP8	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.01.01/EP5	Standard

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP - IC.02.02.01/EP2

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP: §482.52 **Tag:** A-1000 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.52 Condition of Participation: Anesthesia Services

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.52(b)(3)	A-1005	HAP - PC.03.01.07/EP7	Standard

Requirements for Improvement – Detail

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.01.01 ESC 60 days

Standard Text: The hospital manages safety and security risks.

Element(s) of Performance:

5. The hospital maintains all grounds and equipment. 4

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 5
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site for the Hospital deemed service.
The high pressure oxygen cylinders, located outside at the reserve manifold, were not protected against continuous exposure to direct rays of the sun.

Observed in Building Tour at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site for the Hospital deemed service.
The high pressure nitrous oxide cylinders, located outside at the reserve manifold, were not protected against
continuous exposure to direct rays of the sun.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01 ESC 45 days

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Element(s) of Performance:

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)
Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.
Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.51 - (A-0940) - §482.51 Condition of Participation: Condition of Participation: Surgical Services
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site for the Hospital deemed service.
In sterile processing, the hospital was not documenting the lot number of the biological indicators for both the load run and the control. Only one lot number was documented

---

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.04.01.01

Standard Text: Medication orders are clear and accurate.

Element(s) of Performance:

13. The hospital implements its policies for medication orders.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 13
§482.23(c)(3) - (A-0406) - (3) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders in accordance with State law and hospital policy, and who is responsible for the care of the patient as specified under §482.12(c).
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site for the Hospital deemed service.
On the medical floor the medical record contained an order for both Phenergan and Zofran prn for Nausea and Vomiting. There was no indication which medication to start with and when to progress to the other medication.

Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site for the Hospital deemed service.
The medical record of a patient on the Behavioral Health Unit the record contained an order for both Tylenol and Lortab PRN for pain. There was no indication which medication to begin with and when to advance to the next medication.

Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site for the Hospital deemed service.
In a closed record review there was an order for Percocet to be given PRN. There was no indication written for the medication and there was not a clarification order written.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.02.03 ESC 45 days

Standard Text: The hospital makes food and nutrition products available to its patients.

Element(s) of Performance:

11. The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security. 3

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 11

Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site.
In the perioperative area, the weekend of October 3-4 had "closed" listed on the temperature log. The organization is currently not using a thermometer that has recall capabilities or the ability to monitor if the temperature fell out of range over the weekend. Nutrition items are stored in the refrigerator over the weekend.

Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site.
In the perioperative area, the weekend of October 10-11 had "closed" listed on the temperature log. The organization is currently not using a thermometer that has recall capabilities or the ability to monitor if the temperature fell out of range over the weekend. Nutrition items are stored in the refrigerator over the weekend.

Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site.
In the perioperative area, the weekend of October 17-18 had "closed" listed on the temperature log. The organization is currently not using a thermometer that has recall capabilities or the ability to monitor if the temperature fell out of range over the weekend. Nutrition items are stored in the refrigerator over the weekend.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.03.01.03 ESC 45 days

Standard Text: The hospital provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.

Element(s) of Performance:

1. Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. (See also RC.02.01.01, EP 2) 3

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Building Tour at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site.
The medical record of a patient having a procedure using moderate sedation did not have evidence that an airway assessment was completed as required.

Chapter:	Provision of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	PC.03.01.07 ESC 45 days
Standard Text:	The hospital provides care to the patient after operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia.

Element(s) of Performance:

7. For hospitals that use Joint Commission accreditation for deemed status purposes: A postanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. 3

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 7
§482.52(b)(3) - (A-1005) - [The policies must ensure that the following are provided for each patient:]

(3) A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site for the Hospital deemed service.
The medical record of a patient who had a procedure using moderate sedation did not have evidence that there was a post anesthesia assessment documented within 48 hours of the procedure. For form for this assessment was blank.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

ESC 45 days

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Element(s) of Performance:

8. The medical record contains information about the patient's care, treatment, or services that promotes continuity of care among providers.
Note: For hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.

3

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 8
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site for the Hospital deemed service.
The immediate post operative/procedure note in an outpatient patient #1 was not legible

Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site for the Hospital deemed service.
The immediate post operative/procedure note in an outpatient patient #2 was not legible

Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site for the Hospital deemed service.
The immediate post operative/procedure note in an outpatient patient #3 was not legible

Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road, Woodbury, TN) site for the Hospital deemed service.
The immediate post operative/procedure note in an outpatient patient #4 was not legible

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP5
	EC.02.06.01	EP1
	IC.02.02.01	EP4
	PC.01.02.03	EP4,EP5

Opportunities for Improvement – Detail

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.02.01
Standard Text: The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance:

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP5
Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road,Woodbury,TN) site.
In sterile processing there was an eyewash station that was noted to not have a mixing valve. The hot water was not turned off.

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.06.01
Standard Text: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP1
Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road,Woodbury,TN) site.
In a storage room there was an oxygen supply rack that had a full tank and an empty tank stored in the rack. The rack was labeled as full.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Element(s) of Performance:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP4
Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road,Woodbury,TN) site.
In the endoscopy area it was observed that two of four scopes were hanging with the tips of the scopes touching the back wall of the cabinet.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.03

Standard Text: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

Element(s) of Performance:

4. The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 6; RC.02.01.03, EP 3)

Scoring Category : C
Score : Satisfactory Compliance

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP4
Observed in Individual Tracer at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road,Woodbury,TN) site.
In a review of a closed procedural record, the history and physical was dated and timed after the procedure had taken place. The time was after the anesthesia start time as well as being after the time stamp on the rhythm strip.
EP5
Observed in Record Review at Saint Thomas Stones River Hospital, LLC (324 Doolittle Road,Woodbury,TN) site.
In a review of a closed record for a procedure using sedation, the record contains a history and physical from the practice completed prior to the procedure. However, there is not an update to the history and physical that was documented prior to the procedure.

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 3

Site:	Saint Thomas Stones River Hospital, LLC
Building Name:	Stones River Hospital_HAP
PFI Id:	9342
Description:	
Inaccessable fire damper	
ILSM Access:	Unknown
Projected Completion Date:	9/30/2016
Funds Committed:	No
Accepted Date:	10/23/2012

Site:	Saint Thomas Stones River Hospital, LLC
Building Name:	Stones River Hospital_HAP
PFI Id:	9379
Description:	
Inaccessable fire damper inside central supply return	
ILSM Access:	Unknown
Projected Completion Date:	9/30/2016
Funds Committed:	No
Accepted Date:	10/23/2012

Site:	Saint Thomas Stones River Hospital, LLC
Building Name:	Stones River Hospital_HAP
PFI Id:	Sprinkler He
Description:	
Different style sprinkler heads in same hallways	
ILSM Access:	Yes
Projected Completion Date:	8/31/2017
Funds Committed:	No
Accepted Date:	10/29/2015

Final Accreditation Report

Saint Thomas West Hospital
4220 Harding Road
Nashville, TN 37205

Organization Identification Number: 7891
Unannounced Full Event: 5/8/2018 - 5/11/2018

Program Surveyed
Hospital

Final Report: Posted 6/14/2018

The Joint Commission
Table of Contents

Supplemental #2 (Original)

Cumberland Behavioral Health, LLC

CN1806-022

Supplemental #2
July 19, 2018
1:25 P.M.

ANDERSON & BAKER
An Association of Attorneys
2021 RICHARD JONES ROAD, SUITE 120
NASHVILLE, TENNESSEE 37215-2874

ROBERT A. ANDERSON
Direct: 615-383-3332
Facsimile: 615-383-3480

E. GRAHAM BAKER, JR.
Direct: 615-370-3380
Facsimile: 615-221-0080

July 19, 2018

Mark A. Farber, Deputy Director
State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Hand-Delivered

Re: Certificate of Need Application CN1806-022
Cumberland Behavioral Health, LLC
Supplemental Responses #2

Dear Mr. Farber:

Please find attached the Applicant's responses to your second set of Supplemental Questions. Please contract me if you have any additional questions.

Sincerely,

E. Graham Baker, Jr.

Encl: As Noted

Supplemental #2
July 19, 2018
1:25 P.M.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: Cumberland Behavioral Health, LLC, CN1806-022

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.

E Graham Baker, Jr
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 19TH day of July, 2018, witness my hand at office in the County of Davidson, State of Tennessee.

K. Kathleen Baker
NOTARY PUBLIC

N. Kathleen Baker Notary Public State of Tennessee Davidson County

My commission expires JULY 05, 2021.

HF-0043

Revised 7/02

Cumberland Behavioral Health, LLC
CN1806-022

Supplemental Responses 2

1. Cover Letter

The cover letter provided for the first supplemental response was identified as a second supplemental response for CN1801-003, Regional One Extended Care Hospital.

Response: This was a typo. Please accept that initial packet as our First Supplemental Response for CN1806-022.

2. Section A, Executive Summary, B. Rationale for Approval

Please explain what DSM-5 is.

Regarding ED psychiatric wait volume, what is defined as a wait?

Are the volumes the numbers of patients that present themselves at the ED and have a psychiatric diagnosis or is there some other definition?

Why are the wait times at St. Thomas West and Midtown being added together? Is it not correct to say that the wait times at the two facilities range between 4 and 5 hours?

Response:

DSM-5 is the Diagnostic and Statistical Manual for Mental Disorders, 5th Edition. This manual is the taxonomic and diagnostic tool published by the American Psychiatric Association (APA) as the principal authority for all mental health related diagnoses and criteria for establishing the presence or absence of a mental disorder.

Wait time, also referred to boarding time, is the measure of time from admission to discharge or transfer to another care setting (e.g., psychiatric hospital).

The volumes represented are for patients with a primary psychiatric complaint or diagnosis, only. Patients with secondary psychiatry complaints or diagnoses were not included.

The data previously reported was flawed due to a change from ICD-9 to ICD-10 that reclassified psychiatric diagnosis – therefore, the boarding time for those patients was not correctly calculated. The applicant was able to scrub the data once the ICD-9 to ICD-10 system conversion error was identified. The corrected data is below.

Emergency Department Psychiatric Patients Wait Volume

Facility	2015	2016	2017
STM	2,004*	2,233	2,601
STW	1,288*	1,288	1,345
Total	3,292*	3,521	3,946

*Note: * 2015 totals were annualized, as exact figures were readily available for 3 months, only*

In addition, the corrected wait times for those psychiatric patients were:

Emergency Department Psychiatric Patients Wait Time (hours)

Facility	2015	2016	2017
STM	9.8	8.9	8.8
STW	9.0	9.4	9.2
Average	9.4	9.2	9.0

Based on the average wait times for each of the 3 years (2015 – 2017), approximately 10,759 psychiatric patients waited in Saint Thomas Emergency Rooms for approximately 98,852 hours, which is over 4,118 days, or the equivalent of over 11.2 years during the three-year period of 2015 – 2017.

3. Section A, Project Details, Item 4.B (Ownership)

Your response to this item is noted. Please identify the members of Acadia JV Holdings, LLC and each member's percentage of ownership.

Response: Acadia JV Holdings, LLC is 100% owned by Acadia Healthcare Company, Inc., which is a publicly traded company.

4. Section B, Need, Item I.a. (Psychiatric Inpatient Services-Service Specific Criteria-)

Please complete the following tables to determine psychiatric bed need.

	Population 2022	Gross Need Pop. X (30 beds/100,000)	Current licensed beds	Net Need
	Adults 18-64	Adults 18-64	Adults 18-64	Adults 18-64
Proposed Primary Service Area	544,300	164	454	-290
Proposed Secondary Service Area	-	-	-	-
Total	544,300	164	454	-290

	Population 2022	Gross Need Pop. X (30 beds/100,000)	Current licensed beds	Net Need
	Geriatric 65+	Geriatric 65+	Geriatric 65+	Geriatric 65+
Proposed Primary Service Area	115,055	35	100	-65
Proposed Secondary Service Area	-	-	-	-
Total	115,055	35	100	-65

Source: Boyd Center for Business and Economic Research, University of Tennessee, Knoxville. Reassembled by Tennessee Department of Health, Division of Policy, Planning and Assessment. Note: These projections may not match Boyd Center projections precisely due to rounding. [TN_CoPopProj_2017 series (May 2018)]

Response: The chart above is completed. Note that the quoted source provides data in 5-year increments; therefore, there is no data for ages 18 to 64 (the age grouping of 15 to 19 was algebraically divided when computing Adult totals). Also, select pages from the 5 facilities' JARs are attached which verify the number of licensed beds reported by each facility.

Further, the CON application does not identify a "Proposed Secondary Service Area" as envisioned by this chart. Our stated service area consists of Davidson, Cheatham and Robertson Counties. We understand that (if our hospital is approved) patients may originate from outside this primary service area. However, we have no way of specifically identifying either: (1) such areas; or (2) the impact such areas may have on projected occupancy at our hospital.

Finally, the Applicant believes that attempts to apply patient origin data of the Saint Thomas West geriatric unit to the hospital proposed in this application would be imprecise.

Year 2016

SCHEDULE F - BEDS AND BASSINETS

19404 - Middle Tennessee Mental Health Institute

1. PLEASE GIVE THE NUMBER OF:
   A. TOTAL LICENSED ADULT AND PEDIATRIC BEDS AS OF THE LAST DAY OF THE REPORTING PERIOD (exclude beds in a sub-acute unit that are licensed as nursing home beds) 207
   B. The number of adult and pediatric staffed beds set up, staffed and in use on a typical day, 207
   C. NEWBORN NURSERY BASSINETS AS OF THE LAST DAY OF THE REPORTING PERIOD 0
   D. Licensed Beds that were not staffed during the reporting period. 0
   E. Licensed beds that could not be put into use within 24-48 hours 0

2. STAFFED ADULT, PEDIATRIC, AND NEONATAL BEDS (exclude newborn nursery, include neonatal care units):
   Was there a temporary or a permanent change in the total number of beds set up and staffed during the period? ○ YES ◉ NO
   If yes, give beds added or withdrawn (show increase by + and decrease by -) and date of change.

   Bed change (+ or -) _____ Date: _____ Month Day Year
   Bed change (+ or -) _____ Date: _____ Month Day Year
   Bed change (+ or -) _____ Date: _____ Month Day Year
   Bed change (+ or -) _____ Date: _____ Month Day Year

3. SWING BEDS:
   A. Does your facility utilize swing beds? ○ YES ◉ NO If yes, number of Acute Care beds designated as Swing Beds. ____
   B. PLEASE SPECIFY THE FOLLOWING FOR SWING BEDS WHEN USED FOR LONG TERM SKILLED OR INTERMEDIATE CARE:

(How many admissions and how many days did you provide in the following categories?)

INTERMEDIATE CARE	ADMISSIONS	PATIENT DAYS
Private Pay		
Medicaid/TennCare		
Other		
Total	0	0

SKILLED CARE	ADMISSIONS	PATIENT DAYS
Commercial		
Blue Cross		
Medicare		
Private Pay		
Other		
Total	0	0

**Items in Grey will be auto calculated once the preparer leaves that Schedule

SCHEDULE F - BEDS AND BASSINETS (continued)

19404 - Middle Tennessee Mental Health Institute

4. A. Number of Beds Set up and Staffed on a Typical Day	Number of Beds
Burn	
Cardiology (TOTAL)	0
Cardiology - adult patients	
Cardiology - pediatric patients	
Substance Use Disorder (TOTAL)	0
Substance Use Disorder specifically for children and youth patients	
Substance Use Disorder specifically for adult patients	
Substance Use Disorder specifically for geriatric patients	
Chronic/Extended Care	
Eye	
Gynecological	
Intensive Care (excluding neonatal)	
Medical	
Medical/Surgical	
Neonatal Care	
Neurology	
OB/GYN	
Obstetrics	
Orthopedic	
Palliative Care Inpatient Unit	
Pediatric	
Psychiatric (TOTAL)	207
Psychiatric specifically for children and youth patients	
(specific age range based on hospital's preference)	
Psychiatric specifically for adult patients	207
(specific age range based on hospital's preference)	
Psychiatric specifically for geriatric patients	
(specific age range based on hospital's preference)	
Pulmonary	
Rehabilitation	
Surgical	
Swing Beds (for long term skilled or intermediate care)	
Urology	
Other, specify _____	
Unassigned	
TOTAL (This total should equal 1.B.)	207

**Items in Grey will be auto calculated once the preparer leaves that Schedule

Year 2016

SCHEDULE H - PSYCHIATRIC

19274 - Saint Thomas West Hospital

1. TYPE OF UNIT-PSYCHIATRIC:

A. Do you have a dedicated psychiatric unit? (•) YES ( ) NO If yes, please complete items on this page and on the next page

1. Total number of licensed beds 22
2. Total number of staffed beds 15
3. Year unit opened 1975

2. COMPOSITION OF PSYCHIATRIC UNITS:

A. Do you have a Gero-psychiatric unit? (•) YES ( ) NO If yes, please answer the following

1. Total number of licensed beds 22
2. Total number of staffed beds 15
3. Year unit opened 1975

B. Do you have a child and/or adolescent psychiatric unit? ( ) YES (•) NO If yes, please answer the following

1. Total number of licensed beds
2. Total number of staffed beds
3. Year unit opened

3. UTILIZATION BY AGE GROUPS:

Please indicate if you are reporting ( ) **Admissions and Inpatient Days** or (•) **Discharges and Discharge Patient Days**

	Inpatient		Partial Care			Intensive Outpatient (IOP)		
AGE GROUPS	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Patients	Number of Service Days	Number of Visits	Number of Patients	Number of Service Days
Ages 0-12								
Ages 13-17								
Ages 18-64	16	471						
Ages 65 and older	144	3070						
Total	160	3541	0	0	0	0	0	0

4. Is the psychiatric service managed under a management contract different from the hospital itself? ( ) YES (•) NO

If yes,please specify name of organization that manages the unit

5. Does the hospital use the following: If Yes, please complete

		Total Hours				Total Inpatient Days			
Choices	Ages	0-12	13-17	18-64	65+	0-12	13-17	18-64	65+
A. Restraints (•) YES ( ) NO					3267				136
B. Seclusion ( ) YES ( ) NO									

6. Does your facility accept involuntary admissions? ( ) YES (•) NO

**Items in Grey will be auto calculated once the preparer leaves that Schedule

Supplemental #2
July 19, 2018
1:25 P.M.

Year 2016

SCHEDULE H - PSYCHIATRIC

19234 - TriStar Skyline
Madison Campus

1. TYPE OF UNIT-PSYCHIATRIC:

A. Do you have a dedicated psychiatric unit? (•) YES ( ) NO If yes, please complete items on this page and on the next page

1. Total number of licensed beds 152
2. Total number of staffed beds 121
3. Year unit opened

2. COMPOSITION OF PSYCHIATRIC UNITS:

A. Do you have a Gero-psychiatric unit? (•) YES ( ) NO If yes, please answer the following

1. Total number of licensed beds 14
2. Total number of staffed beds 14
3. Year unit opened 2016

B. Do you have a child and/or adolescent psychiatric unit? (•) YES ( ) NO If yes, please answer the following

1. Total number of licensed beds 21
2. Total number of staffed beds 21
3. Year unit opened

3. UTILIZATION BY AGE GROUPS:

Please indicate if you are reporting ( ) **Admissions and Inpatient Days** or (•) **Discharges and Discharge Patient Days**

	Inpatient		Partial Care			Intensive Outpatient (IOP)		
AGE GROUPS	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Patients	Number of Service Days	Number of Visits	Number of Patients	Number of Service Days
Ages 0-12	1	6						
Ages 13-17	670	4663						
Ages 18-64	2597	17337	1891	206	3001	1004	107	2375
Ages 65 and older	208	1919	80	11	120	101	8	205
Total	3476	23925	1971	217	3121	1105	115	2580

4. Is the psychiatric service managed under a management contract different from the hospital itself? ( ) YES (•) NO

If yes,please specify name of organization that manages the unit

5. Does the hospital use the following: If Yes, please complete

	Total Hours				Total Inpatient Days			
Choices Ages	0-12	13-17	18-64	65+	0-12	13-17	18-64	65+
A. Restraints (•) YES ( ) NO		4	2					
B. Seclusion (•) YES ( ) NO		10	10					

6. Does your facility accept involuntary admissions? (•) YES ( ) NO

**Items in Grey will be auto calculated once the preparer leaves that Schedule

Supplemental #2
July 19, 2018
1:25 P.M.

Year 2016

SCHEDULE H - PSYCHIATRIC

19324 - TriStar Centennial Medical Center

1. TYPE OF UNIT-PSYCHIATRIC:

A. Do you have a dedicated psychiatric unit? (•) YES ( ) NO If yes, please complete items on this page and on the next page

1. Total number of licensed beds 132
2. Total number of staffed beds 132
3. Year unit opened 1970

2. COMPOSITION OF PSYCHIATRIC UNITS:

A. Do you have a Gero-psychiatric unit? (•) YES ( ) NO If yes, please answer the following

1. Total number of licensed beds 56
2. Total number of staffed beds 56
3. Year unit opened 1970

B. Do you have a child and/or adolescent psychiatric unit? ( ) YES (•) NO If yes, please answer the following

1. Total number of licensed beds
2. Total number of staffed beds
3. Year unit opened

3. UTILIZATION BY AGE GROUPS:

Please indicate if you are reporting ( ) **Admissions and Inpatient Days** or (•) **Discharges and Discharge Patient Days**

	Inpatient		Partial Care			Intensive Outpatient (IOP)		
AGE GROUPS	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Patients	Number of Service Days	Number of Visits	Number of Patients	Number of Service Days
Ages 0-12								
Ages 13-17								
Ages 18-64	1473	15188				2426	161	
Ages 65 and older	558	9157				35	3	
Total	2031	24345	0	0	0	2461	164	0

4. Is the psychiatric service managed under a management contract different from the hospital itself? ( ) YES (•) NO

If yes,please specify name of organization that manages the unit

5. Does the hospital use the following: If Yes, please complete

		Total Hours				Total Inpatient Days			
Choices	Ages	0-12	13-17	18-64	65+	0-12	13-17	18-64	65+
A. Restraints (•) YES ( ) NO				5	1			15079	14608
B. Seclusion (•) YES ( ) NO				40				15079	14608

6. Does your facility accept involuntary admissions? (•) YES ( ) NO

**Items in Grey will be auto calculated once the preparer leaves that Schedule

Supplemental #2
July 19, 2018
1:25 P.M.

Year 2016

SCHEDULE H - PSYCHIATRIC

19284 - Vanderbilt University Medical Center

1. TYPE OF UNIT-PSYCHIATRIC:

A. Do you have a dedicated psychiatric unit? (•) YES ( ) NO If yes, please complete items on this page and on the next page

1. Total number of licensed beds 88
2. Total number of staffed beds 88
3. Year unit opened 1985

2. COMPOSITION OF PSYCHIATRIC UNITS:

A. Do you have a Gero-psychiatric unit? (•) YES ( ) NO If yes, please answer the following

1. Total number of licensed beds 8
2. Total number of staffed beds 8
3. Year unit opened

B. Do you have a child and/or adolescent psychiatric unit? (•) YES ( ) NO If yes, please answer the following

1. Total number of licensed beds 26
2. Total number of staffed beds 26
3. Year unit opened 1985

3. UTILIZATION BY AGE GROUPS:

Please indicate if you are reporting ( ) **Admissions and Inpatient Days** or (•) **Discharges and Discharge Patient Days**

	Inpatient		Partial Care			Intensive Outpatient (IOP)		
AGE GROUPS	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Patients	Number of Service Days	Number of Visits	Number of Patients	Number of Service Days
Ages 0-12	239	1745						
Ages 13-17	688	5024						
Ages 18-64	2656	19386						
Ages 65 and older	187	1365						
Total	3770	27520	0	0	0	0	0	0

4. Is the psychiatric service managed under a management contract different from the hospital itself? ( ) YES (•) NO

If yes,please specify name of organization that manages the unit

5. Does the hospital use the following: If Yes, please complete

		Total Hours				Total Inpatient Days			
Choices	Ages	0-12	13-17	18-64	65+	0-12	13-17	18-64	65+
A. Restraints (•) YES ( ) NO		32	14	23	1	2142	6025	16843	2109
B. Seclusion (•) YES ( ) NO		18	6	35					

6. Does your facility accept involuntary admissions? (•) YES ( ) NO

**Items in Grey will be auto calculated once the preparer leaves that Schedule

5. Section B, Need, Item 2.e Patients with Intellectual Disabilities (Psychiatric Inpatient Services-Service Specific Criteria-)

Will the applicant have provisions available for patients with intellectual disabilities?

Response: The applicant intends to provide services to patients with intellectual disabilities.

6. Section B, Need, Item 2.f Medical Inpatient Transfer Agreements (Psychiatric Inpatient Services-Service Specific Criteria-)

It is noted the applicant has medical transfer agreements with St. Thomas Midtown and St. Thomas West. Please indicate their distance from the site of the proposed project.

Response: The distance from Saint Thomas West Hospital to the proposed new behavioral health hospital located at 300 Great Circle Road Nashville, TN 37228 is 6.9 miles. The distance from Saint Thomas Midtown Hospital to the proposed new behavioral health hospital located at 300 Great Circle Road Nashville, TN 37228 is 4.1 miles. These distances are estimates noted on Google Map.

7. Section B, Need, Item 2.j Crisis Stabilization Units (Psychiatric Inpatient Services-Service Specific Criteria-) Page 24

Are there crisis stabilization units available in the proposed service area as an alternative to inpatient psychiatric care? If yes, please discuss.

Response: Mental Health Cooperative operates a 16 bed Crisis Stabilization Unit (CSU) located at 260 Cumberland Bend, Suite C, Nashville, TN 37228. This CSU is located less than 1 mile from the applicant's proposed hospital site. Importantly, CSU's are not an alternative to inpatient psychiatric care. Only those patients who have severity of illness sufficient to warrant inpatient psychiatric care are admitted to psychiatric hospitals. CSUs admit individuals in crisis who are considered clinically sub-acute (i.e., not requiring 24-hour skilled nursing, multidisciplinary team, and physician managed inpatient treatment). This distinction is important as the populations served are different. Notably, the clinical services, scope of treatment, severity of illness, and licensing/accreditation required by an acute care psychiatric hospital is substantially higher/different than that which is required of a CSU.

8. Section B, Need, Item 3 Incidence and Prevalence (Psychiatric Inpatient Services-Service Specific Criteria-)

Please use incidence and prevalence data from the following Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) web-site to respond to the Incidence and Prevalence Criteria:

https://www.tn.gov/behavioral-health/research/data--research--and-planning/county-and-regional-behavioral-health-prevalence-dashboard.html

In your response, please also compare the proposed service area to the statewide incidence and prevalence trends.

Response: The applicant's proposed service area includes Davidson (TDMHSAS Region 4), Cheatham, and Robertson counties (both located in TDMHSAS' Region 5). The TDMHSAS' Behavioral Health Prevalence Dashboard for the most recent data available demonstrates the considerable need for psychiatric inpatient services in Regions 4 and 5. As illustrated below, Regions 4 and 5 exceed the prevalence rate compared to the State of Tennessee and dramatically exceeds the prevalence rate compared to the United States for "any mental illness in the past year". Prevalence of "serious mental illness in the past year" is marginally lower than the State of Tennessee and significantly higher than the United States. Regions 4 and 5 bracket the State of Tennessee in prevalence for "serious thoughts of suicide in the past year" and is below the United States. Finally, prevalence for "at least one major depressive episode in the past year was high in Regions 4 and 5 than both the State of Tennessee and the United States. The applicant notes that the TDMHSAS acknowledges receiving low response rates to these questions on a county by county basis, making a more focused analysis at the county level unreliable.

2012-2014	Region 4	Region 5	State of Tennessee	United States
Any Mental Illness in the Past Year	20.5%	20.6%	20.3%	18.4%
Serious Mental Illness in the Past Year	4.4%	4.3%	4.5%	4.1%
Had Serious Thoughts of Suicide in the Past Year	3.9%	4.4%	4.1%	7.4%
Had at Least One Major Depressive Episode in the Past Year	7.0%	7.0%	6.9%	6.7%

In addition to the metrics supporting needs above, the applicant submits commentary and public statements by community leaders and mental health experts published in the May 10, 2018 edition of the Tennessean supporting this application and need for additional inpatient psychiatric beds, as follows:

> The new hospital [Cumberland Behavioral Health] has been proposed at a time when Nashville's need for mental health treatment has likely never been greater. As the city grows at a booming pace, experts say options for mental health treatment have fallen behind, pushing treatment out of reach for many low-income and uninsured residents. Without more specialized facilities, most mental health patients end up mixed in with the physically sick and injured at hospital emergency rooms, waiting to be transferred to somewhere with more appropriate psychiatric services.
>
> This wait averages about 25 hours statewide, according to 2017 study by Tennessee's mental health department. And wait times are not much better in Davidson County, which has been designated a "mental health professional shortage area" for low-income residents by the federal government for the past four years.
>
> "Nashville is not unlike a lot of large cities that are growing," said Amanda Bracht, a senior official with the Mental Health Cooperative, a treatment network that is unaffiliated with the new hospital. "Over the last few years, the number of psychiatric beds in the Middle Tennessee region has simply not been able to keep up with the demand for those services."
>
> **Connections to the opioid crisis**
>
> Bracht said the mental health shortage is also widely viewed as a root cause of Tennessee's opioid crisis, with many addictions beginning after the undiagnosed or the untreated turn to drugs to self-medicate. In other cases, patients are prescribed an opiate for a legitimate ailment, but turn to abuse when they are unable to find the corresponding psychiatric treatment.
>
> "It has a snowball effect," Bracht said. "What starts as a legitimate prescription turns into to something that is masking their need for mental health treatment." …
>
> Davidson County Sheriff Daron Hall, a vocal advocate for increasing mental health services, has said repeatedly that about one third of the inmates in Nashville jails are eventually diagnosed with some sort of mental illness. Hall added Wednesday that the shortage of treatment options is so severe that some families — even families that can afford medical services — will call the police on their mentally-ill loved ones because a jail stay will at least provide a safe space and a psychiatric assessment. Inmates may get help, but the price is a criminal record.
>
> "It is a terrible solution," Hall said. "Nashville may be the 'it' city, but we sure don't do this very well."

9. Section B, Need, Item 16. Community Linkage Plan. (Psychiatric Inpatient Services-Service Specific Criteria-) Page 31

Does the applicant plan to provide support letters from physicians, mobile crisis teams, and managed care organizations in support of the application detailing instances of unmet need for psychiatric inpatient services in the proposed service area.

Please provide the applicant's proposed primary prevention initiatives in the community linkage plan that addresses risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

Response: The applicant will supply letters as described above. Moreover, the applicant has demonstrated through data provided by the TDMHSAS that the average wait/boarding time for patients in need of psychiatric hospitalization exceeds 24 hours in Middle Tennessee. Eventually, all patients receive care in some environment. Too often this includes substantial outward migration of patients from their home county. For example, in 2017, TrustPoint Hospital in Murfreesboro admitted more than 600 patients from Davidson county, many referred by hospital systems with existing psychiatric services who either lacked an available bed or an appropriate service to meet the needs of the patient.

To support clinical psychiatric services at greatest need, this applicant is further differentiating its care by providing services to geriatric patients, patients with cooccurring substance use/abuse disorders, the severely mentally ill, and patients with primary psychiatric illness and secondary intellectual disability. To support this unmet need, the applicant can furnish correspondence from a large Davidson County based provider of inpatient psychiatric services who has offered to contract with and pay TrustPoint Hospital in Murfreesboro, an Acadia Healthcare facility, to accept patients in need of inpatient services where beds are routinely unavailable in Davidson County.

Risk Factor Leading to Increased Likelihood of Inpatient Psychiatric Bed Usage:

The following risk factors, among others, contribute to increased likelihood of inpatient psychiatric admissions:

1. Limited or delayed access to primary (traditional outpatient), secondary (structure outpatient and residential), and tertiary (acute inpatient specialty care) psychiatric care options
2. Inadequate outpatient systems of care
3. Inadequate provider networks to meet need/demand
4. Inadequate payer contracts and access barriers to health insurance threatens low socioeconomic individuals
5. Federal and state government not supporting TennCare expansion and downward pressure on mental health reimbursement by all payers

6. Inadequate public health education and early prevention services – not unique to psychiatry, we see this in other significant areas of medicine, including: cardiovascular health, diabetes prevention, obesity, lifestyle choices, drug/alcohol abuse
7. Socio-economic pressure
8. Limited housing options
9. Lack of support system (i.e., family, friends, colleagues, etc.)
10. New onset/diagnosis of mental illness
11. Stigma related to mental health disease and prevention
12. Erosion of core societal values

The issues contributing to inpatient bed utilization are myriad, complex, and interrelated, as illustrated above. There is no simple solution that resolves these issues. For that to occur, our broader society would need to adopt principles requiring a fundamental shift in how care is conceptualized, financed, delivered, and measured for efficacy. It is a daunting proposition. At the grassroots level, where this application resides, we can materially impact many factors that contribute to mental illness, including its progression, management, and outcomes with a goal of early identification and treatment to reduce inpatient utilization. Societal benefit of these strategies will be measured in years, if not decades, with the help of dedicated providers like this applicant, its community partners, government agencies, and the insurance industry. In order to meet many of these challenges, this applicant has a well-established linkage plan to continue moving toward a time where mental illness is out-of-the-darkness and access to comprehensive high-quality care is widely available.

Linkage Plan: The applicant and its parent organizations, Acadia Healthcare and Saint Thomas Health, are fully committed and have a demonstrated track record in Tennessee for providing high quality inpatient and outpatient psychiatric care that is integrated through direct linkages within their respective health systems and with community partners. The applicant will adopt the best practices of each parent organization to ensure both access to high quality care, including full continuity across levels of care necessary to improve and maintain the patient's condition. The applicant will accept both voluntary and involuntary patients, including those whose disease state would normally preclude them from admission to free standing psychiatric hospitals and other inpatient programs. Specifically, the applicant will accept patient who suffer moderate to severe neurocognitive disorders with disturbance of mood and behavior, patients who have severe mental illness (i.e., who would normally be referred to MTMHI), patients who have a primary psychiatric condition with intellectual disability, and patients who have cooccurring psychiatric and substance use/abuse disorders. Patients seeking services from the applicant will have access to a full continuum of care, including:

- Assessment and triage for need
- Access to care that considers the spiritual/faith dimension of treatment and recovery
- Intensive Outpatient Programs
- Partial Hospital Programs
- Inpatient hospitalization

- Outpatient office treatment (traditional office visits)
- Access to mental health providers via appointment in any of the 105 Saint Thomas Health primary care centers or by tele-psychiatric services to better reach the patient where they are (the applicant is committed to bringing care to the patient and investing resources to meet this important public health determinant for improving access to care and reducing the incidence and prevalence of untreated mental illness)
- Education and support groups and services
- Network of residential care facilities for post-acute drug, alcohol, and psychiatric treatment

Following its existing clinical and treatment models across Tennessee, the applicant will work closely with a variety of providers including other inpatient facilities, outpatient providers, post-acute care drug and alcohol treatment programs, community mental health centers, academic institutions, veteran services, and active military installations. The applicant will work with the following organizations, with whom both parent entities (Acadia Healthcare and Saint Thomas Health) have long standing relationships through our existing treatment facilities and community stewardship:

- National Alliance on Mental Illness (NAMI Tennessee)
- Mental Health America
- The Tennessee Suicide Prevention Network
- Tennessee Department of Mental Health and Substance Abuse Services
- The Tennessee Hospital Association (THA – Psychiatry Section)
- Tennessee Valley Healthcare System
- Centerstone
- Mental Health Cooperative
- Volunteer Behavioral Health
- Davidson, Cheatham, and Robertson County Sheriff and Police Departments
- The Jason Foundation for Suicide Prevention
- The Family Center
- The United Way
- Creating new and innovative programs with payers to improve care within Tennessee

10. Section B. Need. Item C. Service Area,

Please provide the patient origin using admissions by county specific to the inpatient psychiatric unit at St. Thomas West.

If this patient origin from St. Thomas West varies significantly from the applicant's proposed patient origin (Davidson-72.4%, Cheatham-4.5%, and Robertson 8.1%), please discuss the factors that are expected to change the patient origin mix.

Response:

The following table illustrates the total number of patients admitted to the geropsychiatric program at Saint Thomas West from Davidson, Cheatham, and Robertson counties as a percentage of total admissions from all counties for 2015, 2016, 2017.

	2015	2016	2017	Total	Percent
Total Admits	107	189	197	493	
Davidson	56	99	110	265	53.7%
Cheatham	5	7	9	21	4.3%
Robertson	2	2	4	8	1.6%
Other Counties	44	81	123	199	40.4%

The data for Davidson and Robertson county is slightly less than projected by the applicant. Importantly, Saint Thomas West Hospital serves as a regional medical center for care, including multiple surrounding counties. The applicant expects that demand for inpatient geriatric specialty psychiatric care will continue to grow in each of the primary service areas and surrounding counties. There is a dearth of available geriatric psychiatry beds in Davidson County. With the approval of this application, the applicant expects that patients who currently migrate out of the county will be able to receive care closer to their home and healthcare support systems.